R.N.

April, 1953

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2. Lubowe, I. I.: New York State J. Med. 50:1743, 1950
3. Nemland, R.: Postgrad. Med. 11:412, 1952

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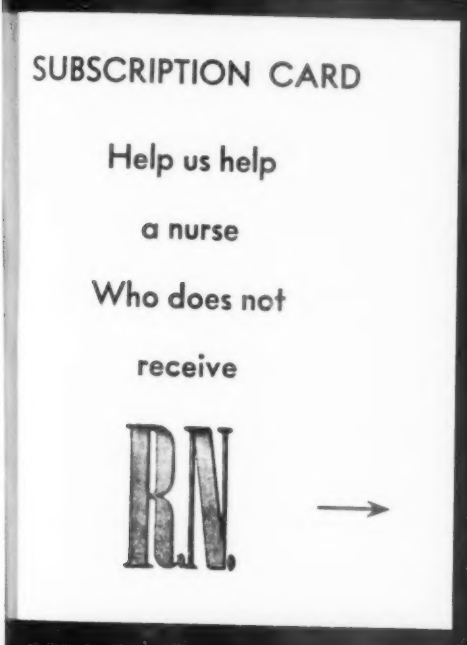
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R.N. Contents — April, 1953

DEPARTMENTS

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let's meet R.N. authors

Marion Wefer, R.N., author of "If the Cap Fits," on page 46, has written plays, articles, fiction, and dramatic criticism and has won several first prizes in playwriting contests. Married to a clergyman, a special interest is religious drama. A graduate of New York's City Hospital, she plans to try her nurse's cap for fit on her 2- and 3-year-old granddaughters.

Just call us Cupid! **Gladys M. Balbus, R.N., B.S.** and **Nathan J. Lipkin, A.B., D.D.S.** collaborated so successfully on "The Nurse's Role in Modern Dentistry," on page 36, that they became engaged. Now practicing in Brooklyn, N.Y., Dr. Lipkin is a graduate of Johns Hopkins University and New York University College of Dentistry. He met Miss Balbus—a graduate of the Cornell University—New York Hospital School of Nursing—while she was head nurse on the obstetric service at New York's Queens General hospital. The poor dentition of many of her maternity patients made Miss Balbus realize the tremendous opportunity nurses have to do some preventive teaching in dentistry.

Sara H. Carleton, a free-lance writer and reporter, has an A.B. degree from Boston University. A long siege of rheumatoid arthritis turned her literary interests to medical subjects and she has written many articles in this field for national health magazines. "One Hospital—Two Innovations," on pages 58 and 59, marks her double-barrelled debut in **R.N.**

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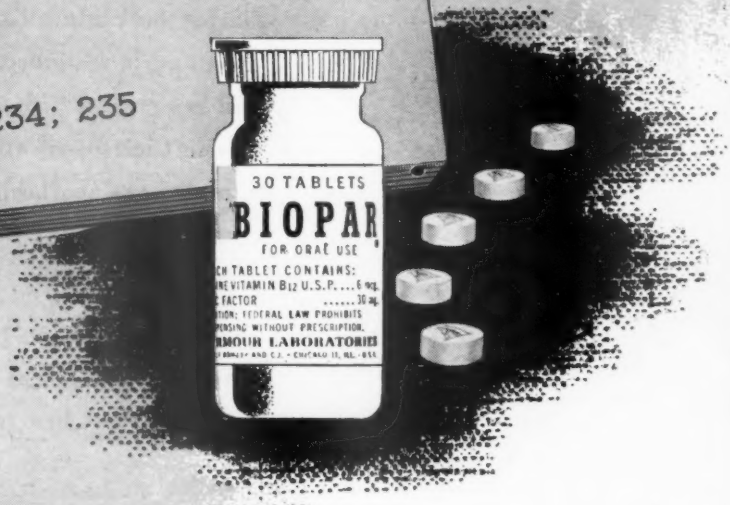

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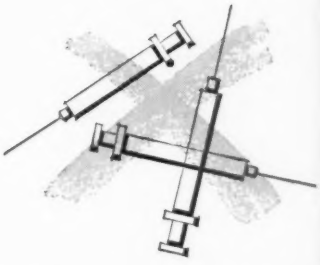

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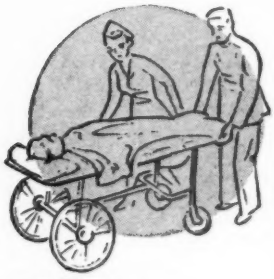

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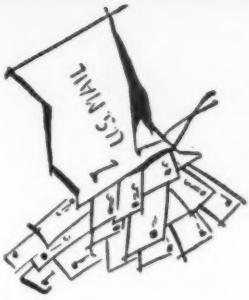


Debits and Credits

NURSERIES NEEDED

Dear Editor:

I'm just dying to go back to work! (And have been for a couple of years now.) Well, you say, why don't you? And the same answers always come up, namely, the three little Williams', aged 4, 2, and 1. I couldn't attempt a full-time nursing job, but I could give at least a day a week IF my children could be cared for, for somewhat less than three-fourths of my day's salary. I know at least half a dozen other R.N. mothers with the same problem. (Our local day nurseries charge $2 per day per child, and refuse care unless the mother works full time.) I love nursing and it makes me heartsick to have month after month roll by while I watch my career grow dustier and dustier, and know I am needed so badly. One day's work doesn't sound like much, but with five or six married nurses working one day each, it would equal one full-time nurse. Won't somebody give us a chance to help?

(Mrs.) Jeanrose Williams, R.N.

KANSAS CITY, KAN.

[*According to* 1952 *Facts About* Nursing, 62.2 *per cent of our total estimated nurse force are married —and* 83.1 *per cent of that number are between the ages of* 20-49; 46.5 *per cent of our estimated number of active nurses are married,* 85.9 *per cent of our inactive nurses are married. Presumably, many of our inactive nurses are staying home to raise families. How many of these nurses would return to at least part-time nursing if adequate provision could be made for care of any children they may have is not an academic question today. It could have a decided effect on easing the present national shortage of nurse power. See page* 58 *of this issue for an article telling how one hospital has provided nursery facilities for young children of married nurses in its employ.*—THE EDITORS]

A BIG CONTRIBUTION

Dear Editor:

Thank you for the copies of the January R.N. containing the article "Now They Can Read—and Write, Too." We have already distributed several hundred plastic mouthpieces for respirator patients to nurses in all parts of the country upon request, and our small contribution toward helping polio sufferers to read, write, and draw gives us a feeling of joy in our hearts. We are happy to supply mouthpieces, free of charge, to those nurses who have patients or friends who could

use them to advantage while they are in respirators. It is, of course, understood that these mouthpieces, which are made by us voluntarily and supplied to interested persons at no charge, are not to be sold by any person for personal profit.

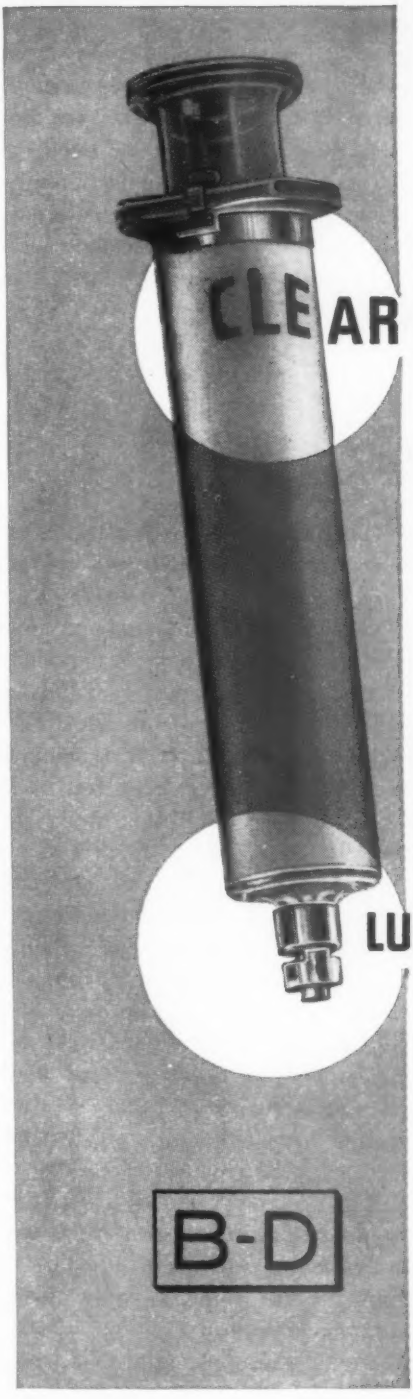
WALTER H. MILLER,
DIRECTOR VOCATIONAL AND INDUSTRIAL EDUCATION
TREVORTON HIGH SCHOOL
TREVORTON, PENN.

SATISFACTION

Dear Editor:

I should like to compliment Janet M. Geister on her excellent article in the September, 1952, issue of R.N. which, I think, embodies the spirit present-day nurses *should* have rather than that which is evidenced so frequently. The self-styled martyrs and the discontented complainers are certainly not getting complete satisfaction from their chosen profession. I have always felt that service is to be considered above monetary returns, and have endeavored to go where I felt I was needed, rather than accepting a position simply because the wage was higher. Also, I have always preferred employment in smaller hospitals to larger institutions because one can achieve a satisfaction from personal service which is impossible as a supervisor in a large department. Some may call it laziness but I don't care to go on and get a degree because I honestly believe I should be dissatisfied in that type of work.

I know there must be other gen-



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eral duty nurses who feel as I do. In closing, I may say that it is not good to place too much emphasis on degree nursing, or we shall find we have more supervisors than we need, and no one remaining who is willing or understanding enough to exercise the kindness and loving sacrifice which has always been the standard of our profession.

(Mrs.) Helen M. Wayman, R.N.
BILLINGS, MONT.

TRAVEL GUIDE

Dear Editor:

R.N. has kept me "in touch" for years. When I didn't pay for it I liked it; now that I do pay, I like it even better. I have moved many times in the last 20 years, and have worked in numerous hospitals all over the country—from Boston to Galveston. The R.N. has been the one thing stable. It occurred to me that other readers who move frequently might like to form a sort of correspondence club to exchange information about various cities. For instance, if a nurse were planning to move to Nashville, Tenn., she could send me a self-addressed envelope and I would write to her, telling her all I know about Nashville and the nurses I know there, and so forth. We all have to learn so much when we go to a new part of the country, it seems that it would be helpful to hear from somebody who has lived where you are going. Right now, I could answer letters of inquiry about Boston, Mass.; Beaumont, and Galveston,

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VERA JOHNSON GARDNER, R.N.
2306 TOREY HILL DRIVE
TOLEDO 6, OHIO

SECOND WIND

Dear Editor:

I especially enjoyed your editorial on the older nurse as I am in that category and have recently found such happiness and contentment.

I am over 60, and until five years ago I had worked in my home hospital for more than 20 years. Sickness caused me to retire from the hospital and I did a little home nursing and baby sitting—enough to keep me in spending money—but I was far from happy. I prayed that I would find something to fit my capabilities and last March I found the answer to that prayer.

I am now working in a 50-bed TB hospital. I have a day off every week and a day and a half once a month. My hours are 7-5:30 with two hours off during that time. I take my "rest period" then and am not over-tired at the end of the day. The work is routine and not hard and I love it. There are three R.N.'s and eight or nine aides. No one here works too hard and there is almost perfect cooperation and harmony.

The grounds are large and like a beautiful park. I go out every night with my crocheting and a

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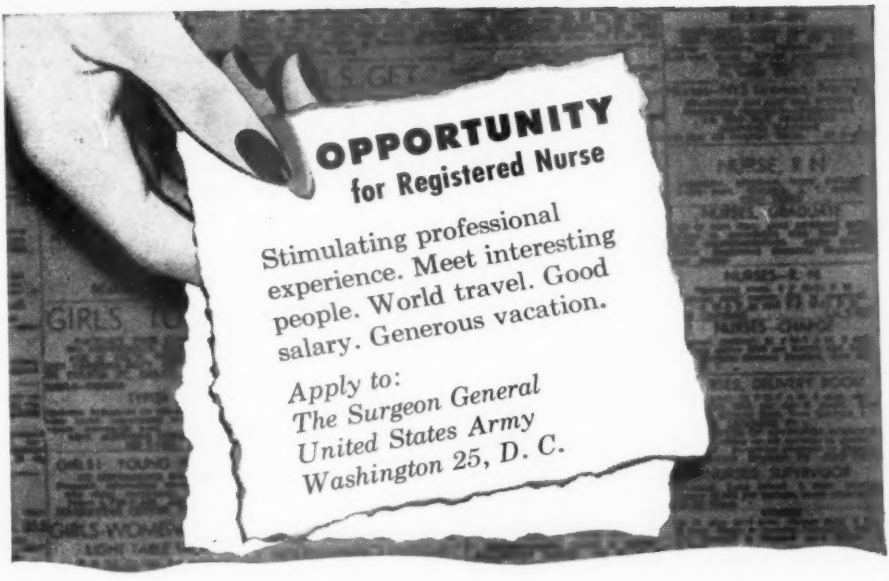

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DON'T WAIT—
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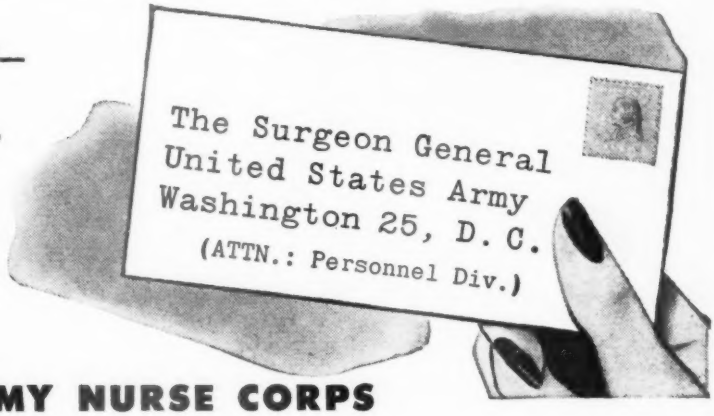

U. S. ARMY NURSE CORPS

book for a couple of hours and thank God that my life is cast in such a beautiful place and that I am still useful though past 60. I wish all older nurses could find such happiness in work suited to their ability and strength.

BERTIE LAFEVER, R.N.
RICHMOND, IND.

HORSE CENTS?

Dear Editor:

What can be done to improve the situation for private duty nurses when a patient decides late in the day that he doesn't want a night nurse, or when a hospital neglects to notify a nurse until she reports for duty that she is off a case? This has happened to me three times in the past year. Unfortunately, I cannot deduct the cost of transportation from my income tax. And what it does to my constitution due to interfering with my sleep schedule can't be paid for even at $14 per day when I do work. Another thing that bothers me is the resentment on the part of hospital authorities when private duty night nurses expect at least coffee in the middle of the night shift. I cannot understand this kind of personnel practice. I was brought up on a farm and I compare the value of a nurse to the high value my father placed on his horses. They were fed regularly and were never overworked—but then, the horses represented a considerable financial investment.

R.N. DAYTON, OHIO

It's the Magic Combination for Nurses!

DOCTORS, PATIENTS, relatives of patients—everybody expects a nurse to look fresh and attractive. And it's a big tribute to the nursing profession that so many of you manage to do this, in spite of long hours of work!

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To make it easier for you to keep your skin looking fresh, lovely—hands soft and smooth, keep a jar of Noxzema where you can reach it every time you've had your hands in hot water or strong solutions.

Smooth on Noxzema before going out into the cold, too—and faithfully each night. You'll see how quickly it helps heal those painful tiny cuts and cracks in the skin—helps soften, smooth and whiten your red, chapped hands. And Noxzema is *greaseless!*

A secret! Keep it under your cap!

A wonderful, new beauty routine to help your complexion look lovelier and help you *keep* it that way!

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NIGHT CREAM—apply Noxzema to help smooth and soften your skin. Always pat a bit extra on any blemishes* to help heal them, fast! It's *medicated!*

MAKE-UP BASE—smooth on a light film of *greaseless* Noxzema as a long-lasting powder base. Many nurses use it instead of powder because it takes away shine and gives an attractive natural finish!

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Be an angel of mercy!

Use Noxzema for your patients, too! It's a refreshing body massage. Makes a patient feel good *all over! Greaseless*—doesn't stain clothes or bed linen! It also helps soothe and heal the sore irritation of sheet burns.

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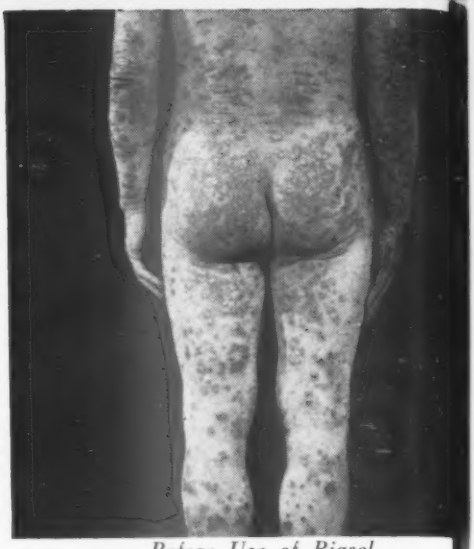
Ethically promoted RIASOL is supplied in 4 and 8 fld. oz. bottles at pharmacies or direct.



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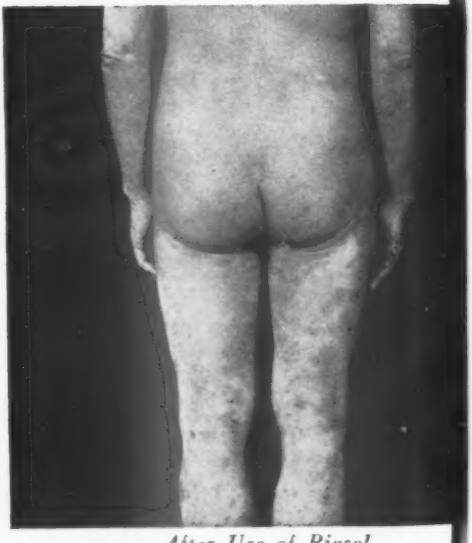

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more effective . . . because they provide healing crude Norwegian cod liver oil (rich in vitamins A and D and unsaturated fatty acids, in proper ratio for maximum efficacy).

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Significant Dietary Advantages Of Fresh-Frozen Minute Maid Orange Juice Over Home-Squeezed Orange Juice Shown By Independent Research

RECENT assays[1] emphasize the nutritional superiority of reconstituted Minute Maid Fresh-Frozen Orange Juice over home-squeezed orange juice in three respects:

a. **Average levels of natural ascorbic acid were significantly *higher* in Minute Maid;**

b. **Peel oil content was significantly *lower;***

c. **Bacterial counts were dramatically *lower.***

Two reasons for Minute Maid's higher ascorbic acid content are advanced:

First, oranges vary widely in ascorbic acid content.[2] Thus, whole oranges squeezed a few at a time provide a highly erratic source of Vitamin C. Each can of Minute Maid, however, represents the pooling of juice from hundreds of thousands of oranges; thus wide variations in nutrients tend to be eliminated.

Second, because it is frozen, Minute Maid loses none of its ascorbic acid content before reaching the consumer.[3] Whole fruit, however, is subjected to variations in temperature, and care in handling cannot be maintained from tree to table. Laboratory tests have shown an average ascorbic acid loss of 10.7% in whole oranges after 11 days under simulated storage and shipping conditions.

Peel oil, cause of allergic response and poor tolerance, especially in infants,[4] is held to an arbitrary minimum in Minute Maid. Samples of home-squeezed juice expressed by typical housewives showed peel oil contents up to 700% higher.

Bacterial counts were found to be as high as 350,000 per ml. in home-squeezed samples—but were uniformly low in Minute Maid. Technicians ascribe this to the combination of rigid sanitary controls in the Minute Maid process and the low pH and low temperatures at which the juice is kept. High bacterial counts in home-squeezed juice are doubtless due to contamination from the exterior peel which is unknowingly added to the juice during preparation.

In view of the above findings, more and more physicians now specify Minute Maid Fresh-Frozen Orange Juice in lieu of home-squeezed orange juice.

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(2) *U. S. Department of Agriculture Technical Bulletin No. 753, December, 1940.*

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Wallace R. Roy, Ph.D., Director of Research

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Because of caffein in regular coffee, it may be against "doctor's orders" for some of your patients. But the New Extra-Rich Sanka Coffee cannot affect the most delicate nerves.

You can serve it to any patient, any time, because it's 97% caffein-free—can't possibly upset nerves or sleep. And New Extra-Rich Sanka Coffee gives a patient all the fragrance and flavor of the fine, rich coffee it is because only the tasteless, odorless caffein is removed.

Why not taste it yourself? And see if New Extra-Rich Sanka Coffee doesn't let *you* sleep better off duty, feel better on duty.

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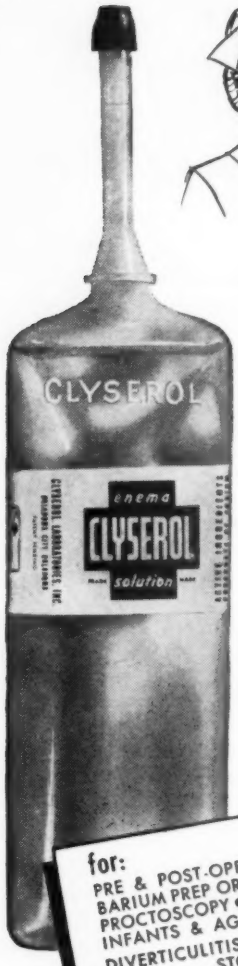
Products of General Foods

NOW—AN ENEMA THAT'S ADMINISTERED IN **ounces**

INSTEAD OF

PINTS



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CANNOT HARM OR IRRITATE MEMBRANES, cannot cause inflammation or toxicity or disturb digestion. This mild solution is non-absorptive and does not interfere with acid base or fluid balance; it evacuates the lower bowel quickly and without undesirable symptoms or discomfort.

TAKES ONLY MINUTES TO ADMINISTER
—usually about five minutes, instead of the usual thirty to forty-five minutes for the average high-fluid enema; an advantage for patient and nurse alike.

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is used for only one patient, then discarded; no cleaning-up, no sterilizing before or after administration. May be kept indefinitely without deterioration of solution or container.

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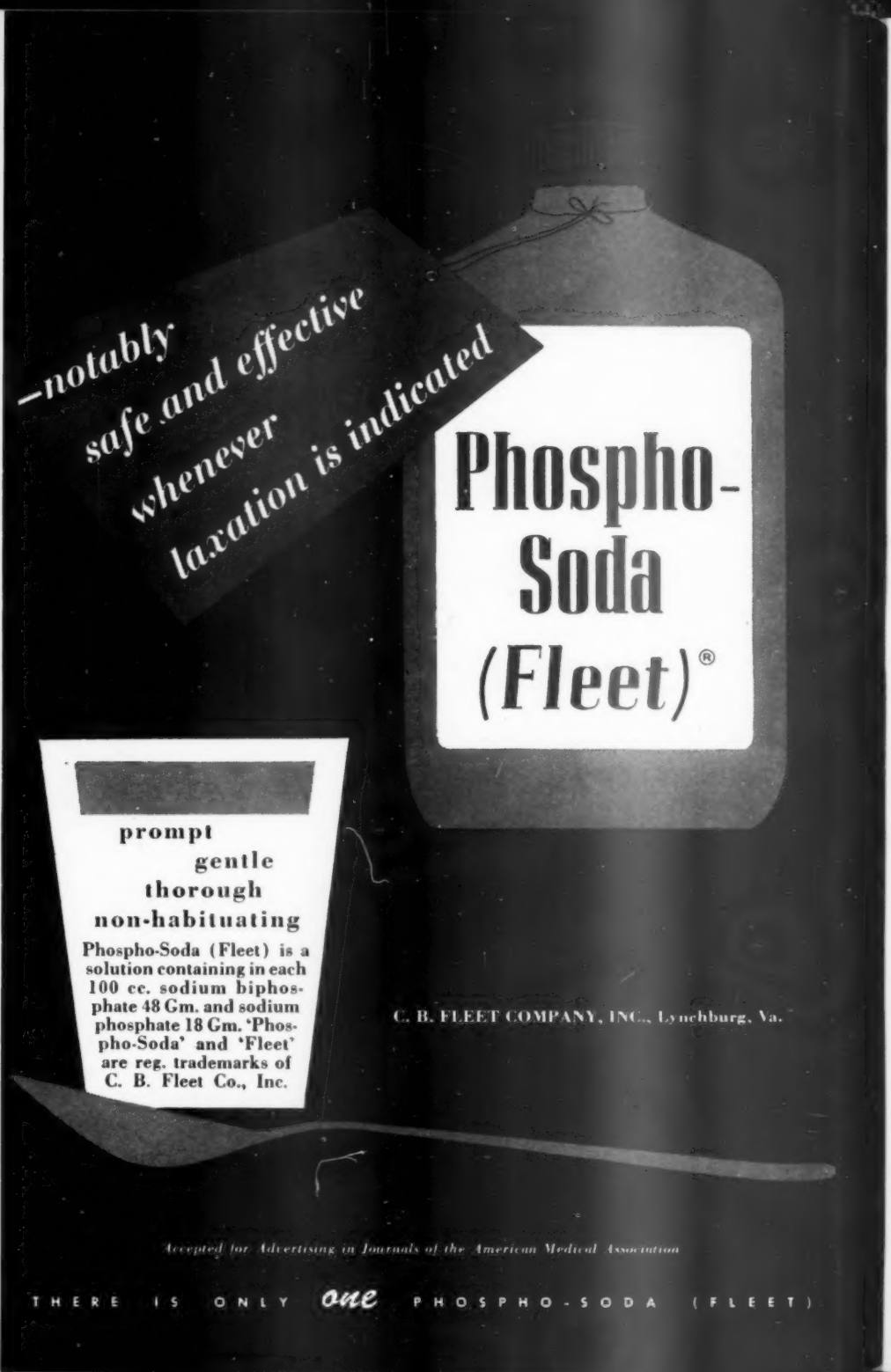
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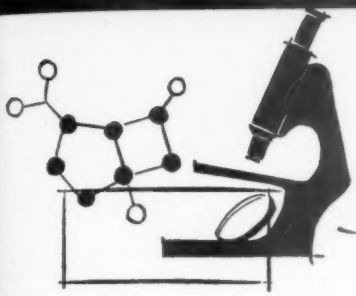

Science Shorts

The prevalent belief that tourniquets should be loosened every half-hour for 5 minutes is unsound, the *Medical Technicians Bulletin*, published by the Armed Forces Medical Publication Agency, asserts. Such a procedure is hazardous in massive hemorrhage where the risk of fatal shock is increased by the loss of blood accompanying each release of the tourniquet. The *Bulletin* warns against the removal of the tourniquet before other means of controlling hemorrhage are available, and states that a tourniquet may be left in place 3 or 4 hours with relatively small danger of gangrene.

*

Although the birth rate in the U.S. has shown a distinct rise as compared with 1950, *WHO statistics reveal that this is not true of most European countries, and particularly of Italy, where a fall in the birth rate has been noted.*

*

An uncommon type of short, periodic headaches which occur in "clusters" has been recently described by Dr. F. Charles Kunkle of Duke University. The headaches, although they greatly resemble migraine, differ from this disease in the lack of "danger signals," rarity of nausea and vomiting, and the brevity and closeness of attacks. The headaches almost always affect the same side of the head and occur largely in men. Duke doctors believe that the headaches arise from the enlargement of arteries either inside the skull or on its surface, but they point out that the evidence is far from complete.

*

Radioactive epinephrine is now available for research purposes in such ills as diabetes.

*

Mild nose drops of the type which causes the nasal mucosa to revert to its normal, slightly acidic state are desirable for the relief of nasal congestion, Dr. Noah D. Fabricant reports in the *JAMA*. According to Dr. Fabricant, this slightly acidic state acts as a barrier against infection. He says emotional disturbances, neurologic disorders, anxiety neuroses, and hysteria, as well as acute nasal infections, weather conditions, allergens, smoke, dust, and chemical substances can cause alkalosis of the mucosa, and also that the use of the wrong type of strong nose drops tends to further irritate the mucous membrane thereby prolonging this alkaline condition.

*

The USPHS reports that the number of new tuberculosis cases reported to state and local health departments fell only 13 *per cent*

from 1947 *to* 1951 *while the annual number of tuberculosis deaths declined by about* 35 *per cent.*

*

Electrocardiographic studies of children hospitalized with measles indicate that an extended period of rest may be desirable following the disease; this is particularly true of children under eight years of age, according to a report in the *American Journal of Diseases of Children.* In spite of the fact that little evidence of cardiac abnormalities was discernible by clinical observation, the electrocardiographs showed "probably abnormal" findings in a significant proportion of the group.

*

Ultra-violet rays are being utilized to examine a tooth's structure; when exposed to these rays the teeth fluoresce, an article in the Journal of the American Dental Association *explained recently.*

*

The relapse rate of Korean malaria has been reduced from about 30 per cent to less than one per cent by the use of the war-developed drug primaquine, preliminary reports in the *JAMA* point out. Also, in acute attacks of vivax malaria, it is advised that primaquine be used in combination with chloroquine, since primaquine is relatively ineffective in destroying the blood stages of the malaria parasite.

*

The population of the U.S. will surpass 160 *million before* 1953 *is over, Metropolitan Life Insurance Company statisticians predict.*

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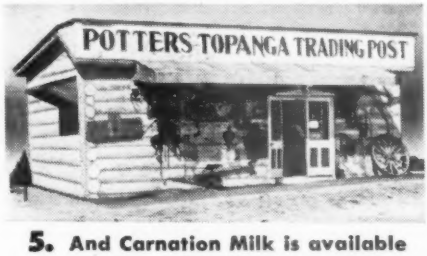

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R.N. *speaks:* To the stockholders

■ THOSE OF YOU who help compose the 177,081 membership figure of the ANA, has it ever occurred to you as you pay your national dues that you are buying preferred cumulative voting stock in a professional venture—in fact, in a corporation whose capitalization is bordering the million dollar mark? The majority of nurses have not had much of an educational or financial opportunity to become familiar with the principles of economics. But to those of you who are investment minded, we ask that you consider, for purposes of analogy, your membership in the ANA and other nursing organizations as voting stock in corporations which pay dividends on your shares; dividends not in cash, but in service to you, and in turn to your patients. And consider also that by virtue of your voting stock, you are allowed active participation in the affairs of the corporation either directly or by proxy.

It is this vote, proxy and direct, that concerns us now, and which, whether you are or are not a member of organized nursing, should concern all of you. For, whether you approve or not, organized nursing is the spokesman for all nurses. It is the nurse members of professional associations who are, however, the ones who are legally responsible for the soundness of nursing's corporations. And these are the nurses who determine what kind of dividends the stockholders will receive for themselves and their patients.

Comes June, and the National League for Nursing members will vote on a new slate of officers. In April, 1954, the ANA House of Delegates will choose new leaders from the ticket prepared by the ANA Committee on Nominations. Once the ticket is completed there will be limitations in choice—usually an either-or decision. Those elected will be nursing's proxies.

The time to choose nursing's future leadership is now, not later at the conventions. Tickets for the fall elections in state and district associations are being made up as we go to press. The ANA Committee on Nominations is at work soliciting names from state associations for the national slate. This is the time to supply this important committee with the best material on hand. The usual procedure has been to pass at this stage of the planning and then later to heap hot coals on the

committee members' heads for drawing up an inadequate and one-sided ticket.

Nursing is on the move, but as it progresses, it is beset by a multitude of gnawing problems that need the thinking of those close to the problems to help resolve them. Who is to answer questions such as: Who shall have degrees?—How can the traditional nurse-patient relationship be preserved?—How far can the nurse carry out the doctor's orders without trespassing on the practice of medicine?—How can better salaries and working conditions be obtained for nurses?—How and where can we get support for nursing education?—And how is nursing service to be paid for in the future?

We have had all kinds of "swivel chair" opinions on these questions. And in most instances, the value of the thinking offered by the "once-removed-from-the-scene" has been nil. True, our problems call for the perspective of time, but they also call for the experience and thinking of those close to the problems. We desperately need to become more adept at mixing our values. There must be a more homogeneous mixture of the old with the new in order to blend old wisdom and experience with new ideas.

We look to our leaders to guide us effectively. We blame them when they don't succeed. Our narrowness in the past robbed nursing of many potential leaders. Nurses with ideas were unwelcome—an idea was not acceptable to the orthodoxy until it had been literally sterilized, sanforized, and de-energized. Leaders, once in office, until remedied by changes in bylaws, remained there. At one time, five members of an ANA eleven-member board had served continuously for terms ranging from 14-20 years.

Weaknesses in our organizations still exist. When finally we do break away from the "old guard" with their tendency toward perpetuity in office, how do we decide upon our leaders? We confuse popularity with leadership. We tend to vote for famous names rather than ability. Also, in summing up their qualifications, their degrees, their positions, little attention is given to the candidates' experience in organization. Again and again, we have elected nurses to [*Continued on page* 72]

BLUEPRINT for the future

R.N. Reviews the Sequel to the Brown Report

■ IN THE PAST few years nursing education has had a thorough going over by professional critics. Doctors have thumped and prodded and emerged with varying diagnoses and treatments; hospital administrators have uttered serious pronouncements; and nurses themselves have had their say—to a considerable degree. Still the discussion goes on, and undoubtedly will continue until there is an adequate supply of competent professional nurses.

The latest fuel to be added to the already crackling controversy on the subject is a book entitled *Collegiate Education for Nursing* by Dr. Margaret Bridgman. The foreword to this report is written, appropriately enough, by Dr. Esther Lucile Brown who, it may be remembered, engendered quite a bit of conversational heat in 1948 with her own report on the situation, *Nursing for the Future*.

Dr. Bridgman's report could, in fact, be considered a sequel to *Nursing for the Future*, for it explores in detail an area which preoccupied Dr. Brown more than a little. Furthermore, both books are published by the Russell Sage Foundation which currently employs Dr. Brown as staff specialist in studies in the professions and which, from September, 1949 to September, 1952, engaged the services of Dr. Bridgman as consultant to colleges desiring to improve or establish schools of nursing.*

Needless to say, there is no disagreement between Doctors Bridgman and Brown as to what course nursing education should follow in the future. Unequivocally, both believe, on the basis of their surveys, that "preparation for nurses who carry professional responsibilities belongs completely within the system of higher education." According to them, the hospital school cannot fulfill society's pressing need for professional nurses, either qualitatively or quantitatively. Only educational institutions, which are not distracted by service needs and which hew to the primary goal of educating students, can supply the demand.

This opinion is one that has long been shared by nurse educators who have called attention to the economic and educational handicaps inherent in the hospital school system. From the writings of one of the best known educators, M. Adelaide Nutting, Dr. Bridgman quotes as follows:

"The crux of the whole situation seems to lie here—education when worth anything is costly, and no scheme of education that will fitly prepare women for the extraordinarily varied demands in nursing can

*Since September, 1952, Dr. Bridgman's services have been continued under the auspices of the National League for Nursing.

OUTLINE OF EDUCATION FOR THE NURSING SERVICES

(Unanimously approved in joint session by the boards of the Association of Collegiate Schools of Nursing and the National League of Nursing Education, January 24, 1952)

Types of preparation	*Location and purposes*
In-service training for auxiliary nursing personnel: aides, attendants, orderlies, etc.	In hospitals: recent high-school graduates with or without vocational high-school preparation in nursing, and mature candidates with suitable personal qualifications. Preparing for simple general functions as assistants to registered nurses or specific functions in a particular service under appropriate supervision.
Practical nurse programs Qualifying for licensure as graduate practical nurses	In vocational school system, above high school but below college grade. Number and purposes of programs related to development of in-service training and education for general registered nurse functions. Preparing for graduate practical nurse functions on nursing team in hospitals and agencies, in nonprofessional home care, and in doctors' offices.
Terminal-occupational lower-division college courses leading to associate degree or certificate. Qualifying for R.N. licensure examination.	In technical institutes, junior colleges, colleges and universities organized to offer such programs. Preparing for general registered nurse functions.
Hospital schools Leading to diploma. Qualifying for R.N. licensure examination.	In hospitals. Better schools to be continued for the present. May be merged ultimately with terminal junior college and baccalaureate programs as educational and financial responsibility is shifted to educational institutions. Any school with adequate financial support and educational emphasis which remains under hospital auspices but with control like that of other schools in the state might be regarded as in same category as private art, business, or music school. Preparing for general registered nurse functions.
Basic baccalaureate curricula Leading to B.S. degree. Qualifying for R.N. licensure examination.	Only in accredited four-year colleges and universities with departments or schools of nursing offering upper-division major or four-year program culminating on senior level in degree-granting institution. Junior and liberal arts college may provide lower-division preprofessional curriculum for university professional schools, or lower-division part of a correlated four-year program by arrangement with an institution offering such a program. Preparing for professional functions in beginning positions and providing foundations for graduate study and advancement.
Supplementary baccalaureate curricula for graduate nurses. Leading to B.S. degree	Existing approved supplementary programs in colleges and universities continued to meet needs. As soon as possible, supplementation should be provided in connection with basic baccalaureate programs, enabling graduates of hospital schools and terminal junior college programs to meet same standards for B.S. degree as students taking complete basic program in the college or university. Specialization transferred to the graduate level. Preparing for greater efficiency in present or prospective positions and providing foundations for graduate work.
Graduate work Leading to M.S. or Ph.D. degree	In accredited graduate schools with standards for nursing equivalent to those in other fields. Admission requirement, the B.S. with a major in general nursing from a college or university with a basic baccalaureate curriculum, as above. Preparing for advanced specialized functions: clinical or public health nursing specialist, research worker, teacher, supervisor, or administrator.

be carried on without expense. The hospital knows this, but cannot meet it. Society has so far not recognized it; while requiring much of the nurse . . . it has left the entire task of educating nurses to the hospital, unmindful of the fact that the hospital is not founded for such work primarily and that it cannot incorporate into its own great scheme of activities another scheme equally great but entirely different in purpose and requiring special conditions and a special government."

In a chapter on the hospital schools, Dr. Bridgman fortifies her stand that learning is subsidiary to service in many of these schools by citing some damaging statistics. Examples of educational sorespots, which she states would not be found in other professional schools, are subject-crammed pre-clinical periods with little time for study, lack of correlation between theory and practice, and scarcity of well-qualified teachers. Even those schools which now offer basic science courses in nearby colleges are not exempt from criticism, for Dr. Bridgman has frequently found that these courses are special "service" courses which "do not conform to college standards." Although she concedes that remarkable progress has been made by certain hospital schools and that under optimum conditions *large* hospitals may meet both patients' and students' needs, she must perforce conclude that although "hospital schools are legally designated 'professional schools,' they obviously do not fit into that category as it is generally defined in higher education."

Another objection which Dr. Bridgman raises against the continuance of the hospital school as the *chief* means of supplying nursing personnel relates to recruitment. It is her contention that high school graduates—the main reservoir of personnel for nursing—fall into four groups. Immediate employment is the goal of one group; a second desires a short vocational course. Still a third group is attracted by junior college or two-year courses, and a fourth by general or professional education in colleges and universities. According to Dr. Bridgman, nursing has lost potential recruits because of the lack of nursing programs for both the third and fourth groups. In her words, "The remarkable expansion of facilities for, and the rapid increase of the proportion of students in, junior and senior colleges during the past three decades have been subjects for frequent comment in discussions of educational and social progress. But nursing education has had an almost negligible share in these developments." She reveals that in January, 1951, less than 5 per cent of the 102,509 students enrolled in schools of nursing were in basic programs in nursing for which higher education accepted direct and complete responsibility.

There appears to be no question then in Dr. Bridgman's mind that nursing education must gradually be integrated into the national system of higher education which already provides post-high-school education for other occupational groups. The

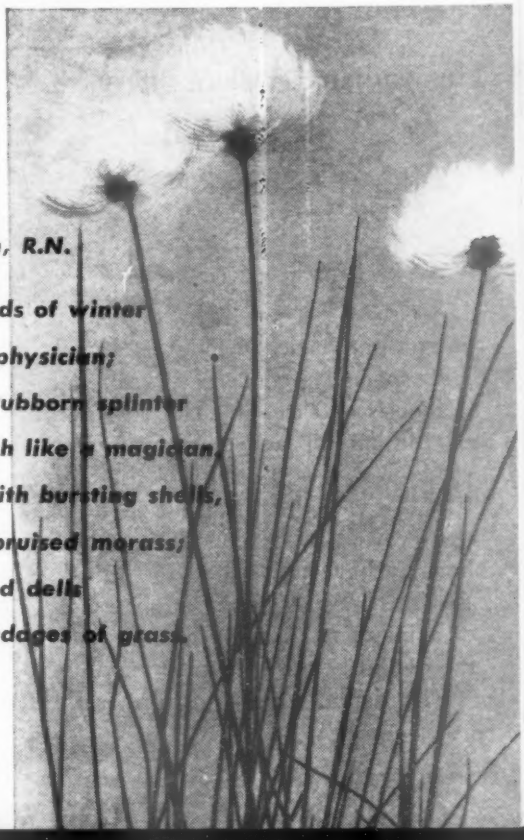
goal, as she sees it, is that "at least a third and probably more nearly a half of the nurses in the area of general nursing should have an educational foundation that would qualify them for the most inclusive staff-level functions and enable those with the interest and ability to advance quickly to positions of larger and more specialized responsibility." Preparation for this type of nursing, now almost the exclusive domain of the diploma school would, of course, be provided by basic baccalaureate programs in colleges and universities. Education for the remainder of staff level nurses would consist of a two- or three-year course in a hospital school or junior college. Although the latter occupies an insignificant position in nursing education at present, Dr. Bridgman believes that "if junior college curricula were extensively established to replace hospital school programs, the chief emphasis could be shifted from the service to be obtained from students to the educational goals." If this educational plan were carried out, hospitals would be relieved of the increasingly heavy financial burden of educating students and could serve as laboratories for the supervised practice of students. Furthermore, if hospitals were freed from the educational demands of students, they might devote more time to in-service training of auxiliary personnel.

At first glance, this plan, which in Dr. Bridgman's [*Continued on page* 66]

BANDAGES OF GRASS

by Nicholas Lloyd Ingraham, R.N.

Oh I've seen April bind the wounds of winter
As skillfully as any trained physician;
And I have watched her pull a stubborn splinter
Of ice from spring's cool flesh like a magician.
I've seen the soil pock-marked with bursting shells,
The fields a crimson battle-bruised morass;
Then I've seen April visit hills and dells
And heal the scars with bandages of grass.



The Nurse's role in Modern Dentistry

by Nathan J. Lipkin, D.D.S.
and
Gladys M. Balbus, R.N.

■ THE DENTISTRY of today is a medical specialty concerned with the diagnosis and treatment of disorders of the mouth and its surrounding structures. It is the duty of the dentist, as it is of the physician, to aid in the prevention of conditions which he may have to treat in the future. For this reason, public education is of primary importance in improving the dental health of any community.

The dental nurse directs most of her energies toward patient instruction. From the youngster learning how to manipulate the toothbrush to the patient learning to manage a prosthesis, there are many opportunities to institute a positive teaching program. Since the dentist usually works alone, the dental nurse usually acts as his assistant, preparing instruments and fillings, suctioning, taking and developing x-rays, giving anesthesia (if she has been so trained),

and retracting when necessary. The nurse's rapport with the patient will aid in all phases of the dentist's work, especially in lessening fear and making the patient more receptive to necessary procedures which may otherwise be regarded with suspicion and with fear.

Throughout this country, dental societies have educational programs in which the nurse plays an extremely active part. She is sent to public schools where she lectures on the importance of proper oral hygiene and demonstrates the use of the toothbrush for massaging and cleansing. She explains the adequate diet, and stresses personal habits which would keep a patient in good health. In addition, since dental clinics are now an established part of medical centers, the hospital nurse plays an important role by helping to integrate dental health programs with the various other services which the clinic offers.

Inasmuch as the problems of dentistry actually have their start in utero, prenatal dietary instruction is imperative, for when the fetus is but five months old, calcification of the deciduous teeth begins. Nutritional deficiencies during the child's first six years of life will also affect the permanent teeth. This is due to the fact that the calcification of the first permanent molars begins at about the time of birth.

It is estimated that half of the children of two years of age in cities have at least one cavity. In view of this widespread presence of dental decay in children, the nurse should stress the importance of periodic visits to the dentist at six-month intervals, starting at the age of four, if not earlier. A full-mouth series of x-rays is advisable, since most cavities are in the approximal surfaces of the molars, and are difficult to detect otherwise. Study casts, taken by means of impressions, will aid in the diagnosis and treatment of an incorrect bite.

When cavities are found in the teeth of young children, the decayed teeth worth saving should be filled as though they were permanent teeth, in order to prevent the penetration of caries to the large pulp chambers. If salvage is not feasible, or if the carious tooth will normally fall out within six months, extraction should be carried out immediately. When extraction proves necessary, a space maintainer may be inserted to prevent shifting of the adjoining teeth from taking place.

At present, experimental studies of small concentrations of fluorides (less than one part in a million) in drinking water, or direct application of a 1:1,000 sodium fluoride solution to the teeth three times a year, are being carried out. These appear to be of help in lowering the incidence of dental caries in children.

Routine dental examinations for the adult should include exploration for cavities, tests for mobility of teeth, cleansing and scaling as needed, and x-ray studies. The examination often reveals conditions for which medical consultation is required. Scurvy, pellagra, syphilis, diabetes mellitus, cretinism, measles,

and other infectious or industrial diseases have oral manifestations which are often first noticed by the dentist. Moreover, oral lesions requiring surgery may be brought to light and the patient can be alerted to the need for surgical care.

Dental surgery is divided into two categories: exodontia (the extraction of teeth), and major oral surgery. Exodontia is usually a simple surgical procedure, and is commonly undertaken in the dental office. With the development of the newer anesthetic drugs and techniques, an extraction need no longer be a painful experience. Local anesthesia by injection is the anesthesia of choice in dentistry. Apprehensive patients may need to be premedicated with the barbiturates or even a narcotic agent.

There are occasional patients who require or demand a general anesthetic. Unruly children and patients who are Novocain-sensitive fall into this group. General anesthesia, when administered in a dental office, is a serious and dangerous procedure unless proper precautions are taken. A competent anesthetist (often the nurse) is needed in addition to the oral surgeon. The patient should be questioned as to the presence of any medical contra-indications, and as to the last hour of food ingestion.

A nurse should be present any time that general anesthesia is administered to a female patient. This is particularly true when nitrous oxide is used, since sexual fantasies under anesthesia are frequent.

When given to ambulatory patients, a general anesthetic should be short acting and quickly liberated from the body. Nitrous oxide and oxygen, although widely used, is not the anesthetic of choice since the proper degree of relaxation is not acquired. However, nitrous oxide in combination with synergistic agents, such as Vinethene or Pentothal Sodium, is effective, since the additions are extremely short-acting, easily and quickly eliminated, and afford greater relaxation while allowing the use of a larger percentage of oxygen. This, however, may be used only for short and uncomplicated procedures.

When the extraction has been completed, the patient must be watched carefully for signs of hemorrhage or aspiration. The patient is instructed to bite on the gauze packing which has been inserted, and to remove it after three hours. No mouth washes are indicated the first day, but lukewarm saline can be used the next day. The teeth may be brushed on the following day, but care should be taken not to injure the operative site. The diet is as tolerated.

General anesthesia for major oral surgery such as the removal of an impacted tooth, fixation of fractures of the jaw, or repair of cleft palates, should be administered in the operating room of a general hospital. The patient then requires an adequate medical work-up prior to surgery. Intubation is necessary during general anesthesia for these procedures, since packing is placed at the back of the throat to prevent the aspiration of blood or teeth.

Whether in a private office, a den-

tal clinic, or a hospital situation, sterile technique for surgery must be maintained. Because the mouth is the dirtiest area of the body, the possibility of postoperative infection is great. Antibiotics are frequently used by dentists today as a preventive measure.

The restorative aspect of dentistry is both a science and an art. It includes any phase of dental work from the insertion of the simple amalgam filling in a tooth to the construction of a partial plate or of a full set of dentures.

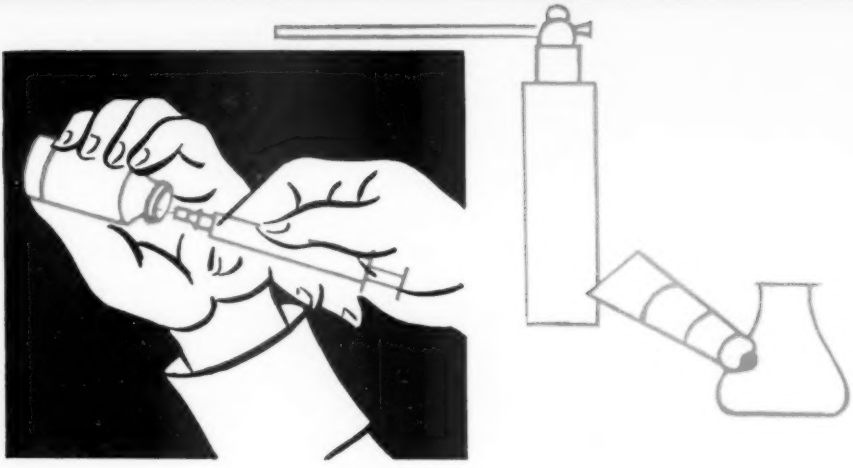
Approximately half of the dentist's time is spent in the removal of tooth decay and replacing that part of the tooth ravaged by caries. This is usually done with a silver, gold, or silicate filling, but another material may be utilized. The choice of substance is affected by the size of the cavity, the location, and cosmetic considerations. The cavity must be dry of all saliva to accept any type of filling, and must therefore be suctioned well. Suctioning is usually the nurse's responsibility, as is the mixing of cement or amalgams for fillings.

The construction of any dental prosthesis requires accurate study casts, and the use of an articulated model to check muscle action and occlusion. Prior to this, the mouth should be at its optimal degree of health. Proper mouth hygiene is of the utmost importance in order to prevent further damage while the prosthesis is being prepared.

In preparing study casts, the dentist is often [*Continued on page* 65]

Probie

"Have you a pass?"



Pain Prevention—or *nobody*—but *nobody*

■ "THE STITCHES didn't hurt a bit—all I felt was the hypo needle."

Remarks such as these are now commonplace—they are heard almost daily by nurses and laymen alike, so widespread is the use of local anesthetics. Many a harassed head nurse has been known to sigh with relief upon learning that the pre-operative patient down the hall is to have local instead of general anesthesia. To her, local anesthesia means, among other things, that she won't have to detail a member of her staff to sit with the patient until consciousness returns—a drain on her already inadequate supply of personnel.

It is a well-known fact that if painful stimuli are waylaid in their journey to the brain, pain sensations cannot be felt. Local anesthetics act to block these stimuli before they reach the spinal cord by paralyzing the sensory nerves from their points of origin to their endings in the skin and mucous membrane. Protoplasmic poisons such as phenol or quinine and urea hydrochloride injure the nerve endings chemically so that they are unable to transmit stimuli. However, since these compounds also damage the body tissues, they are used only infrequently for anesthetic purposes. Temporary anesthesia also results when tissues are "frozen". Certain volatile liquids such as ethyl chloride, or carbon dioxide "snow", will evaporate almost immediately when applied to the skin. Enough heat is absorbed during this process to freeze the tissues, thereby inactivating the nerve endings.

Most anesthetics in use today show a definite affinity for nerve structures. These drugs, structurally related to cocaine, temporarily block the conduction of nerve impulses—although no one knows the exact mechanism of action underlying this interference.

For centuries, Indians chewed the leaves of the cocaine-containing coca-plant as a means of combating fa-

tigue, but it was not until 1884 that this drug was first used in surgery to effect complete, but temporary, sensory paralysis. Unlike other common local anesthetics, cocaine also produces vasoconstriction in the area of application, preventing the hasty absorption of the drug into the blood stream. Consequently, the local anesthetic action is intensified and prolonged and the chances of systemic toxicity are lessened. Cocaine is now used only for instillation in the ear and eye and for topical administration to the mucous membrane. Unfortunately, cocaine dilates the pupil and this mydriatic effect may continue for a number of days. Also, if frequently applied, corneal ulcers may develop. There is the possibility, too, of drug addiction.

Obviously, it was to the advantage of all concerned if an anesthetic agent could be developed which, while retaining the anesthetic properties of cocaine, would prove to be of lower toxicity. After a number of attempts such a compound was synthesized in 1905. Related chemically to cocaine, this compound, procaine, is much less toxic, especially when injected subcutaneously. And, although a number of relatively safe local anesthetics similar to cocaine have since been developed, procaine remains one of the most widely used of all. Since most of these new anesthetic agents, including procaine, do not possess the vasoconstrictor properties of cocaine, epinephrine hydrochloride may be added to prolong the local anesthetic action. Procaine is of particular value in infiltration and various nerve block procedures.

In infiltration anesthesia, the drug is injected into or under the skin in the area where pain is present or is expected to occur. By this means, the nerve endings at the actual site of operation are paralyzed. When the nerve itself is affected, nerve block results and both motor and sensory paralysis may ensue. In nerve block, the anesthetic is injected directly into the nerve sheath (intraneurally) or in the immediate vicinity of the nerve (paraneurally).

It has recently been found that the addition of hyaluronidase to local anesthetics will, in certain instances, increase the area of anesthesia and the rate of induction. This enzyme destroys hyaluronic acid, one of the intercellular "cements" which acts as a barrier to prevent the diffusion of fluids in the tissues. Hyaluronidase, as well as phenol, ethyl chloride, and tetracaine hydrochloride, are discussed in *Drug Digest* page 44.

Spinal anesthesia, now very common, is actually a form of nerve block. The local anesthetic is injected into the spinal canal, and anesthetizes the spinal nerves just before they merge with the spinal cord. Blocking of sympathetic and motor nerve fibers as well as sensory nerve fibers occurs. A fall in blood pressure, due in large part to the dilatation of the arterioles is usually brought about

likes to be *hurt* ~ by Althea Powers, R.N.

by the blocking of the sympathetic fibers. Respiratory paralysis has also been known to develop in spinal anesthesia. This may be due to two factors: the depression or paralysis of the medullary respiratory center as a result of the drugs being absorbed into the general circulation and being carried to the brain by the blood; and upward diffusion of the local anesthetic when used in high concentrations for spinal anesthesia. This may result in paralysis of the phrenic and intercostal nerves—the motor nerves which innervate the skeletal muscles used in respiration.

Another form of nerve block is caudal anesthesia. The local anesthetic is deposited in the sacral canal outside the dura—the outer covering of the spinal cord. It is possible to administer continuous caudal or spinal anesthesia by means of a small, flexible needle or long catheter. By this method, a smaller beginning dose of anesthetic may be given, and further doses may be administered as the need arises. Continuous caudal anesthesia is used most commonly for the relief of labor pains.

Headaches, and nausea and vomiting are not unusual following spinal anesthesia. There are several theories as to the origin of these headaches. One theory is that they may be due to leakage from the spinal cord along the path of the puncture. As a result, the brain is deprived of the cushion of spinal fluid which is normally interposed between it and the venous plexus at its base. Such headaches, aggravated by sitting up, are usually relieved by lying flat. Conversely, there is a type of intense headache following spinal anesthesia which can be relieved by sitting up and made worse by lying down. Theoretically, these headaches are caused by an aseptic meningitis which arises from chemical irritation of the meninges. In aseptic meningitis, the pressure of the cerebro-spinal fluid is increased, while in leakage, the pressure of this fluid is reduced.

It is believed that nausea and vomiting may arise either from the handling of the viscera at the time of operation or from stimulation of the vomiting center by the anesthetic agent. Cases of palsy, paralysis, and vertebral arthritis have been noted but these can usually be attributed to improper technique, overdosage, or poor choice of the anesthetic agent.

All local anesthetics are considered toxic if absorbed in a high enough concentration by the general circulation. The toxicity varies with the drug employed, its concentration, the site and speed of its application, and the emotional and physical make-up, including the age, of the individual receiving the drug. A safe rule is to give the smallest possible dose of the least toxic drug available. Extreme care must be exercised in applying anesthetic solutions to injured mucous membranes to guard against too rapid absorption of the drug. However, not all reactions occurring during the administration of a local anesthetic are due to the anesthetic itself. Some reactions are psychogenic in nature like those seen in persons who faint at the mere glimpse of a needle. Others may

actually be due to the epinephrine contained in the anesthetic solution. Allergy type reactions have been observed too, but these are rare.

What actually takes place in practically all severe reactions to local anesthetics is an overstimulation of the central nervous system to the point of depression. Signs of stimulation such as apprehension, talkativeness, restlessness, tremors, and twitching may appear which may eventually be followed by generalized convulsions. Barbiturates are sometimes given as a prophylactic measure prior to the administration of local anesthesia. If signs of excitement develop, one of the ultra-short acting barbiturates is given intravenously. This should be administered slowly, and the dosage should be carefully gauged in order to minimize the depressing effects of the barbiturate on the respiratory center.

Although it is believed that there is at least a transient phase of stimulation before depression sets in, it is possible that the first symptoms noted may be those of depression—fainting, pallor, cyanosis, and palpitation are warning signs. The administration of oxygen is indicated as soon as it becomes apparent that a reaction is in the making. Watchful care and effective treatment at the first warning signs of reaction are mandatory, otherwise death may result from respiratory paralysis. Death from cardiac arrest may also be caused by large intravenous doses of certain of these anesthetics. It has been found, however, that procaine, if given slowly and with care, is of benefit in a number of conditions, including intractable pain and the prevention of cardiac arrythmias.

Giddiness, dilatation of the pupils, tearing, flushing of head and neck, and a peculiar feeling of warmth all over the body may follow the intravenous administration of procaine. Severe reactions are rare and apparently develop only in persons sensitive to the drug. By modifying the procaine molecule and substituting an amine group for an oxygen atom, a new compound, procaine amide hydrochloride (Pronestyl N.N.R.), with local anesthetic properties similar to those of procaine has been developed. Since Pronestyl does not decompose as readily as procaine, its action is more prolonged. This new compound has been found to exert an amazing specificity for the heart ventricles [*Continued on page* 82]

COFFEETIME

Daily "coffee breaks" for staff physicians and nurses are provided by more than 77 per cent of the U.S. hospitals polled in a nationwide survey. Principle benefits of the breaks, the survey revealed, were reduced fatigue, an improvement in morale, and increased efficiency. Coffee breaks also tended to cut down on the danger of mistakes made while on the job.

Drug Digest

Tetracaine Hydrochloride U.S.P.

(Local Anesthetic)

PRODUCT NAMES: Ophthalmic Ointment Pontocaine Base, Pontocaine Hydrochloride "Niphanoid" for Spinal Anesthesia, Solution Pontocaine Hydrochloride 1%, Solution Pontocaine Hydrochloride 2%, Solution Pontocaine Hydrochloride for Caudal Anesthesia, Tablets Pontocaine Hydrochloride.

PHARMACOLOGY: Tetracaine, about 15 times as effective as cocaine topically, is also superior to procaine in producing surface anesthesia of the mucous membrane and eye. It does not dilate the pupil, raise intraocular pressure, or paralyze the ciliary muscles. Tetracaine is used in spinal, caudal, infiltration, and nerve block anesthesias where it exhibits a prolonged effect. It is also employed for topical anesthesia of eye, nose, throat, skin, and rectal areas.

DOSAGE: As with all local anesthetics in this group, dosage is always kept to a minimum. Recommended concentrations are 0.5 per cent for topical application to the eye; 1 or 2 per cent for the nose and throat; and 0.15 or 0.5 per cent for spinal anesthesia. In caudal analgesia, in infiltration, and in nerve block anesthesia, an 0.15 per cent solution is used. Epinephrine hydrochloride 1:1,000 is sometimes added for its vasoconstricting effect.

UNTOWARD ACTIONS: Nausea, vomiting, rapid pulse, fainting, and convulsions may result from overdosage. As with any local anesthetic, it is necessary to use extreme care when applying the drug under conditions likely to result in trauma to the mucous membrane. This is especially true of the trachea and urethra. Urticaria and other local reactions may occur due to sensitivity or prolonged use.

Ethyl Chloride U.S.P.

(Local Anesthetic)

PRODUCT NAMES: Distributed under U.S.P. name

PHARMACOLOGY: Ethyl chloride is employed in the form of a spray when a short and superficial anesthesia is required as, for example, before the insertion of a trocar. At low temperatures and under an increased pressure, the drug exists as a colorless, extremely volatile liquid with a boiling point between 12° and 13° (Centigrade). Immediate evaporation takes place when ethyl chloride is liberated from its sealed container at room temperature. In the course of this rapid volatilization, enough heat is absorbed to cause freezing of the tissues when the drug is sprayed on the skin. The peripheral nerve endings become inactive for the time being and insensitivity to pain results. Ethyl chloride is of value in the treatment of sprains and has been employed by inhalation as a general anesthetic although the margin of safety between anesthetic and toxic doses is too small for this use to be practical.

DOSAGE: Ethyl chloride is available in specially constructed, sealed glass dispensers or metal tubes, both of which are equipped with spray caps. The drug is kept in a cold place away from the light.

UNTOWARD ACTION: Ethyl chloride is applied only to intact skin, and is not recommended for the opening of boils and abscesses because of its detrimental effect on the nutrition of the area to which it is applied. The patient must be warned against inhaling the ethyl chloride vapor when the drug is used to produce anesthesia on or about the face—otherwise an anesthesia of a dangerous depth may result. Due to its great inflammability, ethyl chloride is never used near a flame.

Phenol U.S.P.

(Local Anesthetic)

PRODUCT NAMES: Distributed under official U.S.P. name

PHARMACOLOGY: Phenol, a protoplasmic poison, acts as a local anesthetic because of its traumatic effect on the body tissues including the sensory nerve endings. In dilute form, phenol has been employed to afford relief from itching and burning such as occur in urticaria, sunburn, and other comparable conditions. Camphor is sometimes added to phenol preparations on the supposition that camphor decreases the caustic effect of phenol. Commonly known as carbolic acid, phenol has germicidal as well as anesthetic properties.

DOSAGE: Dilute solutions are anesthetic and only mildly irritant. Phenol is found as an ingredient of a number of lotions and ointments, and is frequently added in a one per cent concentration to calamine lotion. Castor oil or alcohol may be used to remove phenol from the skin.

UNTOWARD ACTIONS: Phenol dressings are sometimes used for burns and other painful ulcerations, but the drug appears to have an adverse effect upon the nutrition of the area to which it is applied, resulting in gangrene. Tissue necrosis may follow prolonged contact with phenol. And absorption from the skin may become great enough to cause symptoms of systemic carbolic acid poisoning such as nausea and vomiting, collapse with pallor and cold sweats, stupor, and respiratory disturbances. In undiluted form and in strong concentrations phenol has a caustic effect.

Hyaluronidase N.N.R.

("Spreading Factor")

PRODUCT NAMES: Alidase, Wydase

PHARMACOLOGY: The enzyme, hyaluronidase, through its hydrolytic effect on hyaluronic acid, an important component of the intercellular "cement substances" of body tissues, permits the rapid spreading and absorption of fluids given subcutaneously. When used with local anesthetics, hyaluronidase hastens the rate of induction and increases the anesthetic effect.

DOSAGE: Manufacturers of hyaluronidase define their product in terms of viscosity units or turbidity reducing units. The drug, available in the dried form, is usually made up into a solution consisting of 500 viscosity units or 150 turbidity reducing units per cc. of isotonic saline. It is best to prepare the solution just prior to administration, for hyaluronidase in solution deteriorates upon standing. Doses vary according to the amount of anesthetic required and the site of injection. When large amounts of anesthetic are needed for nerve block or infiltration, 500 viscosity units or 150 turbidity reducing units of hyaluronidase and 0.5 cc. of epinephrine 1:1,000 may be added to each 50 cc. of anesthetic solution.

UNTOWARD ACTIONS: Although uncommon, sensitivity reactions to hyaluronidase have been reported; therefore, a test dose of approximately 0.02 cc. of hyaluronidase solution injected intradermally is usually employed. The drug is never injected directly into an area of local infection for fear of spreading the infection. When used to facilitate hypodermoclysis, the dose, the rate of injection, and the type of solution must be adjusted to the individual patient. Solutions devoid of inorganic electrolytes may produce unfavorable symptoms, whether or not hyaluronidase is used for subcutaneous diffusion.

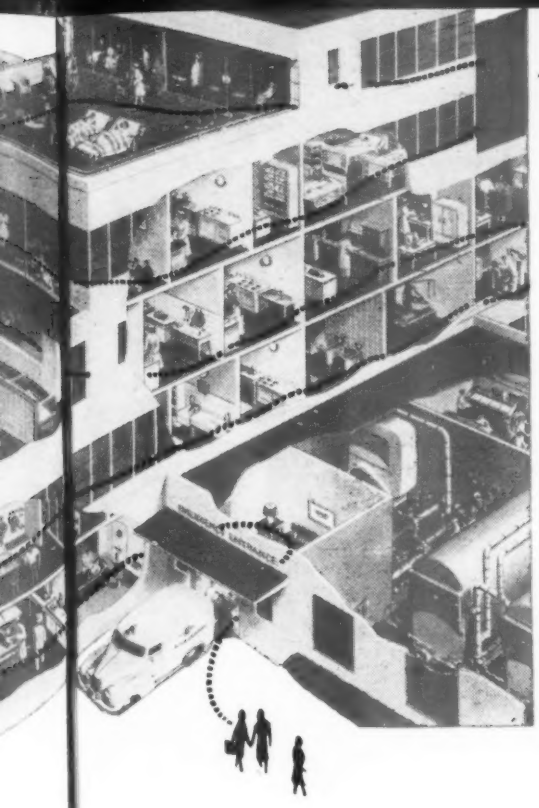
If the cap fits...

■ "I WAS NEVER interested in nursing since I had no idea what it was really like." So reads the candid confession of a high school student who was recently exposed to a two-day nursing orientation course at the Presbyterian Hospital in Philadelphia. She was answering a questionnaire in which young explorers of the nursing world were invited to speak their minds freely about their findings. This same student, who had never been interested in nursing before, also answered, yes, to the all-important question: "Do you feel that you want to become a nurse?"

Thus an original plan for nurse recruitment is off to an encouraging start in this eighty-one-year-old hospital which graduated its first class of eight students in 1891, and since that time has sent out some fourteen hundred and fifty-six graduates into every field of professional nursing. There have been innumerable appeals in the press, on billboards, over the radio, in specially prepared films, and on television for young women to prepare themselves for a nursing career. But none of these has the immediate impact of the imaginative recruitment project launched by the Presbyterian Hospital.

Under this plan, an invitation is sent to a recommended high school graduate or student to visit the hospital, room with the student nurses in the nurses' home, and in as reasonable a facsimile as possible, live the life of a student nurse for two days. In effect, the hospital's nursing school says: "See! Here's a nurse's cap. Would you like to try it for size? Well, if the cap fits—why not wear it?"

This is how the plan was set in operation. Letters were sent to clergymen, staff doctors, alumnae of the nursing school, graduates from other schools who had worked in the hospital, and the student nurses themselves. These were not stereotyped general requests for cooperation such as automatically fill up waste baskets, but letters which appealed to individual reasons for helping in the nurse recruitment undertaking. The



by Marion Wefer, R.N.

doctors' help was enlisted to "*provide good bedside nursing for the patients you entrust to our care.*" Student nurses were told to "think of all the girls you know, high school graduates, seniors, or recent graduates, *whom you would like to have as fellow students.*" The italics are the writer's and I think they give a clue to the success of this approach to an urgent problem.

After a mailing list of suggested names was secured, a descriptive leaflet together with an application form was sent to the prospective guests. "Here Is Nursing for You," proclaimed the leaflet, and with friendly informality it outlined the two-day program from 7:45 A.M. of the first day when "You register" to 4:00 P.M. of the second day when you are "Off for home to tell your friends."

Applicants came from Philadelphia, nearby Pennsylvania towns, and neighboring New Jersey. There was even one from Staten Island. It is interesting to note that one visitor in answering the invitation of the anonymous questionnaire to submit comments or suggestions wrote, "Would it be advisable to publicize this program more? Not just in the vicinity of Philadelphia, but also for students in other cities?"

The first day for the visitors began with the showing of a film, "This Way to Nursing," which set the stage for the two-day drama of Life in a Hospital. Next there was a demonstration by an instructor of nursing arts of bedside nursing featuring that silent and long-suffering patient, "Mrs. Chase." This was followed by a complete tour of the hospital. In the afternoon the young women saw how to care for a surgical patient, and visited the children's ward. Here they were allowed to entertain the convalescents by reading and playing the gentle games permitted the small patients. "There we did something instead of just watching," records one girl with satisfaction as she listed the visit to the children's ward as the "thing I liked the most," on her questionnaire. It is an illuminating

comment, and future programs are hoping to follow her lead and work more participation into the plan. It may be that in the future visitors will be assigned to student nurses and be able to help them actively in some of their routine duties. Giving out nourishments, helping with P.M. care, or feeding helpless patients are possibilities.

After being entertained by the student nurses in the evening and spending the night in the nurses' home, the group opened the next day's adventures with a discussion of the experiences of the day before. Following that the visitors went to the science laboratory, then to see a demonstration of care for a medical patient and, in the afternoon, to the clinic to see the work of the hospital for the people of its own neighborhood. "I liked being in the clinic," wrote one student, "one of the things I liked was how clean everything was." The dramatic quality of the operating room captured the guests. It, together with the children's ward, ranked highest among the "things I liked the most."

The program ended with a general discussion of "Your Way to Nursing" which was largely given over to questions and answers. The girls wanted to know exactly how to qualify as student nurses, and how they might direct their high school studies to that end. They wanted to know all about job opportunities. What about nursing in the Army, the Navy? What about nursing in public health or in industrial plants? What about jobs with the airlines? They were surprised at the variety of positions open to the nurse of today. They also considered the variety of caps and what nursing school to choose and why? At 4:00 P.M. when they left the hospital, they had all the answers.

Forty-seven girls were pioneer observers in this new approach to nurse recruitment. It can hardly be expected that all 47 will return to enrol in the nursing school, but some will undoubtedly decide that "the cap fits." And whatever the outcome, the program is an excellent example of the promotion of public relations, for 47 girls and their families and friends now know hospital life more intimately and sympathetically than before. The visitors were frequently impressed, and a little surprised, at the friendly attitudes as the grim impersonality of an institution cracked wide open for them. Here are some significant comments. "The friendliness of the student nurses gave me a *better feeling* toward them . . . All of the students seemed to like nursing . . . They were all cheerful and helpful when I asked them anything . . . Your students like their training . . . They were very good to us . . . It was very nice of them to entertain us the way they did." One observer would have liked to stay longer. Another concluded, "The two days were just time enough to get acquainted with everything."

Time will furnish the figures, percentages, and statistics required to declare the experiment a proven success, but the prognosis, professionally speaking, is favorable. Distinctly so!

Candid Comments

PENCILS and PEOPLE

■ SINCE EVERY field influenced by science has moved into a new era, the use of statistics has become a major element in our activities. "In the history books of the future," writes Joseph Wood Krutch, "this age of ours may come to be called The Age of Statistics. In the biological and physical as well as social sciences, statistics have become as they never were before, the most important tool of investigation." The movement is so fast and so intensive that new tools must be devised for measuring and evaluating what is being done. Opinion polls, surveys, experiments, and all their accompanying paraphernalia of score cards and questionnaires are multiplying constantly.

We cannot get along safely or well without the tools of investigation. The early plane pilot found his base mainly by a sense of direction and a simple compass. Today his machine is more powerful, swifter, more complex; his loads are larger and his responsibility for human life greater. Science has provided him with instruments that guide him more safely and surely. So it is with nursing. Our loads are larger and our responsibilities greater. We too must devise new tools of measurement and evaluation to guide us to the safest and surest route. There is danger, however, if we become so fascinated by statistics that we use this one tool as our only "tool of investigation."

Statistics can only measure quantity, not quality. And quality was never more important than now, as nursing takes a larger role in the health scene. Statistics can measure but never evaluate; they can tell us how many and how much, but not how good. We can learn what functions the nurse performs, how long each function takes, what amount of travel is involved, but we cannot learn from statistics what manner of nurse carried out the tasks, and her effect on patients' health and morale. In one institution, for example, it was revealed by a study that head nurses, without the help of a clerk, spent over one third of their time in nonnursing clerical duties. The study proved the need for ward clerks, but it could not show what attitudes the head nurses had about supervision, nor their comprehension of its principles. Did they long to be free of clerical tasks in order to help staff nurses bring out their best powers? Free to give more time to learn and to apply their knowledge to help meet patients' needs?

Nursing is a service to humans by humans. Thus it holds in it many in-

by Janet M. Geister, R.N.

tangibles that cannot be measured quantitatively. And if, as seems to be the trend quite generally in other areas, we rely too exclusively on the tangibles, the intangibles go into eclipse. Character, insight, sensitiveness to situations, judgment, mercy, and love are as much a part of nursing as skill and knowledge. It is just as important to know what kind of person a nurse is as it is to know what she does. What has she made of nursing, and what has nursing made of her?

Efficiency without humanity is less desirable than humanity with lesser efficiency. In a clinic proud of its large volume of work, I observed two nurses with identical jobs. The first approached a young mother who clung rather desperately to the hands of her two small children. "The doctor says you have tuberculosis," said she flatly. "Take this bottle,spit into it tomorrow morning and bring it back here." That was all. The other nurse's patient was also a young mother. The nurse sat beside her, and with infinite kindness broke the tragic news. She assured the woman she would be helped in arranging care for her family during the sanitarium stay. "We caught this early! And it's going to be all right. Remember we'll help you all the way."

On paper each nurse had "instructed the patient," but no written word could capture the stunned misery in the first woman's eyes, nor the relief in the other's. We cannot know the end results of these two approaches, but we do know that fear and worry are harmful. And we also know that the first nurse lacked some of the highest essentials to good nursing—sensitiveness, mercy, and love.

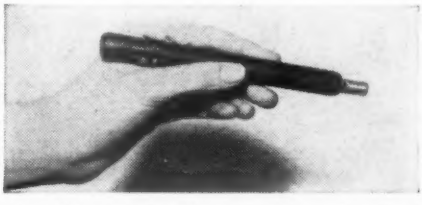
There are no precise instruments for evaluating the intangibles. For this we must depend on the tried and true system of observation—observation by authorities who stay close to the job, who know what to look for, and how to recognize what they find—who themselves are imbued with the spiritual as well as intellectual qualifications they look for in others. We all know that a poor supervisor can break a good nurse; we know too that a good supervisor can bring out the best in the staff. We cannot in wisdom plan by numbers alone—so many hands and feet pitted against so much nursing need. I believe the statement to be true that six good nurses under a competent supervisor can outwork twelve mediocre ones under a weak supervisor. Everything moves in such mass form today that the individual gets lost in the shuffle. Yet we know that our future depends upon what we as individuals make of ourselves and upon what we make of our profession.

The surface of the lake doesn't reveal what is below; we must plumb the depths to know the real character of the water. So it is with people and their situations; we must go beneath the measurable elements to complete the story. On one survey I went out with a nurse on whose record was written "Difficult—sullen—never gets her work done." Never have I seen warmer welcomes than in the homes that nurse and I enter-

ed; her families loved her. And never have I seen more beautiful nursing. That nurse's love and understanding of people flowed out through her hands, her quiet voice, her gentle courtesy. Every family was helped by her presence. Then why, I asked her finally, was she so mean at the station? She replied in effect that the mutual antagonism began with the supervisor's scolding her before the staff for her "inefficiency." "I *am* a poor organizer. I linger. But I *hate* being made to feel like a worm." The pity of it was that any good supervisor, able to "see" people and willing to leave her desk, could have remedied this fault, and helped bring out the full powers of this superb nurse.

Years ago I was sent to evaluate a visiting nursing association. My statistical analysis showed a dark picture; this staff was trying to do a tractor job with a jeep. Then I went out to get the "feel" of things, in the clinics, in visits to homes, in talks with doctors, nurses, and others —and my reaction changed. Here was a staff that in its short five years had overcome almost insuperable odds. Their work could not be measured by the standards of veteran associations, but only by what their achievements and spirit presaged for the future. It was this spiritual strength, this unity and ability, that moved my committee to approve this agency—a decision events have proved well justified.

Observation isn't just being with a nurse to watch for slips in techniques, or to see that the day's work gets done. If that's our concept we had better stay at our desks. The observer must enter the nurse's situations with interest, sensitiveness, and perception—and be eager to learn. As we learn from our patients, so do we learn from our staffs. The individual who learns something from every personal contact finds profit and adventure in every day's living. It is our attitudes, our penetration, our ability to listen, our knowledge of what is important to observe, that makes our footwork count. There are, of course, some supervisors who can rarely leave their posts, like the director of an industrial nursing staff who meets with her home visiting staff every morning. Together they talk over the patients on the day's schedule. She is so accessible, so



• A magnetic probe, no larger than a fountain pen, which is particularly useful in removing steel splinters from the eyes and skin has been devised. The G—S Magnetic Probe can be sterilized without harming the magnet. To regulate the strength of the probe, the length of the magnet protruding from the case is adjusted in much the same manner as is done with the lead in the mechanical pencil. For further information and the price of the probe, write to General Scientific Equipment Co., 2700 W. Huntington St., Philadelphia 32, Pa.

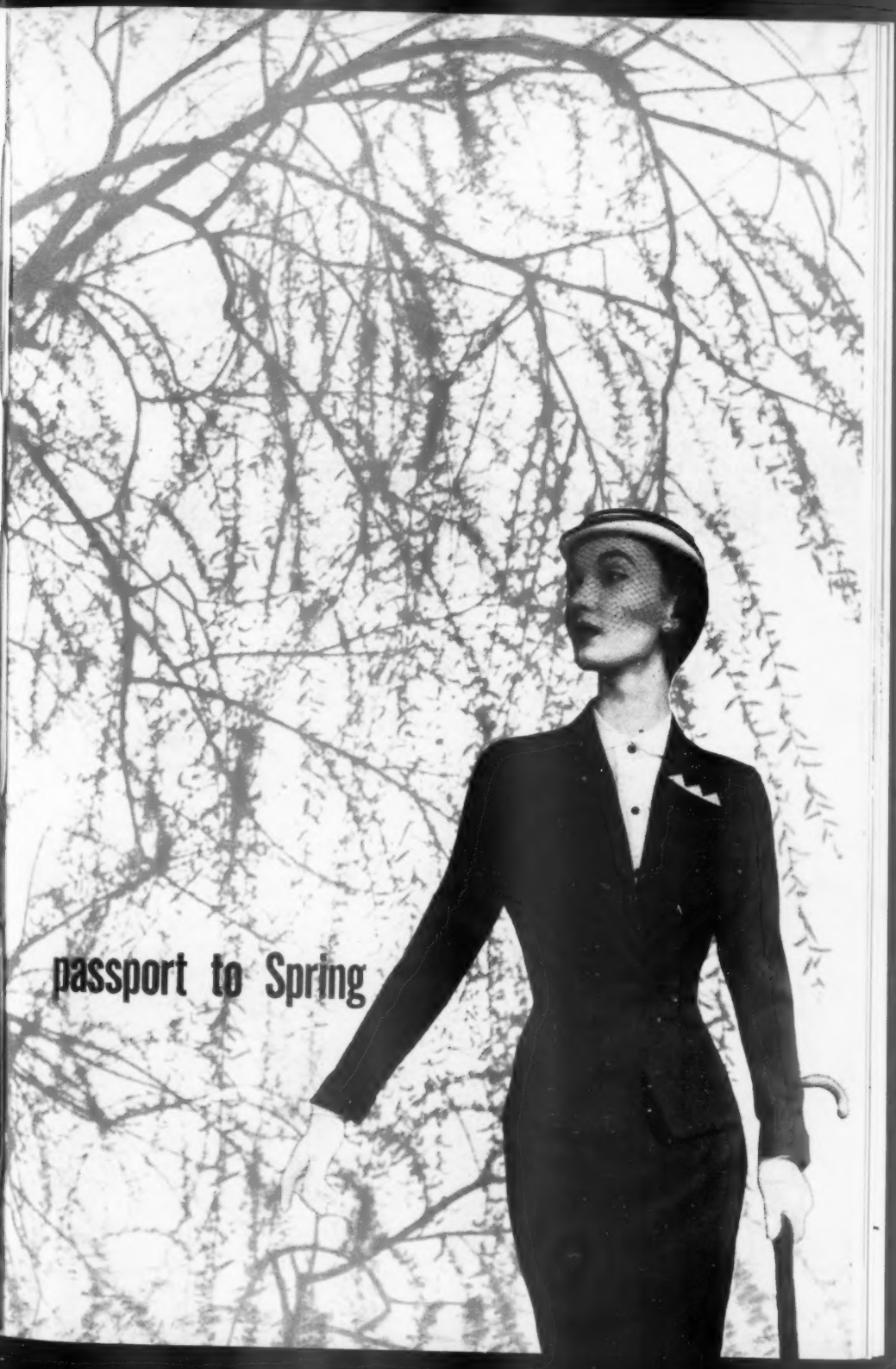
eager to learn, to share, that through her morning meetings with them she knows each one of her nurses, and each one's abilities, thoroughly.

The need for studies of our functions and activities is imperative. So revolutionary have been the changes in our health world that all the old lines of demarcation have been knocked galley west. We don't know the precise legal and ethical line between the practices of medicine and nursing. We don't know where the professional nurse safely leaves off and the non-professional begins. We don't know how much and what kinds of nursing our patients need—in fact we're not sure of just what is nursing. We need more time studies, more footstep studies. We need to understand our relationships with the ever-growing groups who make up the other health personnel.

Nurses *want* answers to these questions. More and more they are moving out to come to grips with the problem of good patient care. The generous and prompt response of members of the American Nurses Association to its request for contributions for its Functions Study program gave direct and unmistakable evidence of nurses' awareness of the need for functions studies. This awareness has grown, and now, by vote of the ANA House of Delegates, one dollar of every member's national dues is allocated to this purpose. Furthermore, many nurses are actively participating in various phases of functions studies. In the the past our research was centered mainly on long-term, nationwide surveys carried on by special staffs. Today multitudes of intensive, localized projects are under way over the country, financed heavily or mainly by nurses, and carried on by them with energy and interest.

Every finding will add to the pool of knowledge that grows as our study programs gain momentum. Inevitably, these studies in the tangible aspects of nursing will bring out the facts we so greatly need. We need to know our place in the health scene. We need a greater efficiency in the use of nursing services. We need the higher morale that comes with the assurance that there has been an equitable division of duties.

We must remain acutely aware, however, that efficiency alone cannot preserve the intrinsic intangibles that *complete* the cycle of good nursing. We need to put as much thought and weight on them as we do upon the tangibles. Character, insight, judgment, sensitiveness to situations, mercy and protective love may be "gifts" to some individuals and absent in others, but they can be stifled or brought into full bloom according to the quality of the leadership and opportunities the nurse encounters. They do not lend themselves to statistical study, but their values and place can be determined by other means. Each of us, as well as our leaders, has a duty to think and work for their preservation. The "spirit of nursing" has been diffused and disoriented by the sheer burden of events, but it is very much alive—and it remains a prime essential to patients and profession alike.


passport to Spring

Spring is a song . . . a robin . . . a crocus . . .
an urge for new clothes! But R.N.s are very special women,
so their clothes must be special too!
Good beginning, the tailored suit on the preceding page,
crisp as celery, in Tanbro men's wear rayon,
its lapel piqué-iced like a man's pocket-handkerchief.
Then, as no wardrobe's complete
without its rain-or-shine coat, softer suit,
print dresses, they're shown too—
specifics for R.N. Spring fever.

by Francia Hughes

➤ Spring coat, hat, umbrella—water-repellent and Temp-Resisto-lined! All this, and in iridescent acetate-taffeta, too, for $35! From Aquatogs.

➤ The Palm Beach suit, tailored for men, gone soft for women, arching its hips, nipping its waist, buttoning high to a winged-collar. Sacony, $25.

➤ Spring elegance: Leonard Arkin's yellow rosebud-dotted navy taffeta; skirt, full; waist, nipped; hipline, yoked —a yellow nosegay at collar. $49.95.

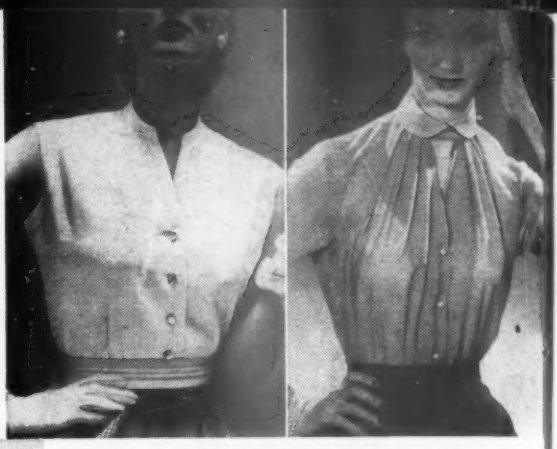
➤ Two for one, or a costume that acts as suit or dress! Arkin & Schrader's pretty silk print with nipped jacket, and full, stitch-pleated skirt. $39.95.

For names and addresses of stores nearest you carrying items you want, write to makers listed on page 104.

Shop Talk

Is it a blouse? Is it a cardigan? Fashion says, "Both! And washable too!" White birds-eye piqué by Ship'n Shore, $2.98. ➤

Kato's peep-hole shirt has buckram-bolstered club-collar. In Tanbro breeze-weight nylon-orlon-rayon blend. Around $3. ➤



➤ Half-coif of wavy straw braid, fresh-as-paint, and veiled and tied with tiny snowballs. An Amy Hat by Frances Nelkin. $7.

➤ Braagaard grows a white organdy rose from the brim of a tilted rough straw sailor, wrapping both up in misty veiling.

Hattie Carnegie creates a bonnet of frosty braided straw, plants white silk carnations around its lofty 2-ringed crown.

Spring debutante: Sacony's "Cherish," lightweight girdle combining best features of bias, lateral and diagonal control in new circular panels.

3 time and beauty savers: Tussy's "Finishing Touch," liquid foundation, $1*; Coty's "Instant Cleanser" in squeeze bottle, $1.50*; Max Factor's "Creme Puff," powdery make-up base that clings like cream, $1.25*.

*plus tax

Calling all Nurses

Northeastern Hospital, Philadelphia, Pa. graduates: 1953 is our 25th Anniversary Year for the Alumnae Association. We are making plans for this silver reunion. If you have not kept in touch with us, please send your maiden name, present name, and address to Mrs. Irene Mergel, R.N., 2403 Hancock St., Philadelphia 33, Pa.

Wilma J. Egdorf of Waterloo Iowa, Please get in touch with Fran and Gerrie: Mrs. R. J. Leighton, 5043 Premiere, Long Beach 11, Calif.

Graduates of St. Mary's School of Nursing, Milwaukee, Wis. Please send name and present address if you haven't received your questionnaire for our Roster for the school's Sixtieth Anniversary. It's to be illustrated and we want news about you and all our graduates. We'd like to complete it by June, 1953. Mrs. Irene A. Wellnitz, 2929A South Howell Ave., Milwaukee 7, Wis.

Mrs. Henry Miller formerly Sally Chesluk, graduate of Brooklyn Hospital. Please write to me. Esther F. Meng, 104 W. Bannock, St., Boise, Idaho.

Graduates of Massachusetts State Infirmary: The Alumnae Association is planning its 50th Anniversary celebration in May. All graduates who have not been contacted recently by the Alumnae Association are urged to send their names and addresses to Alice Bernard Coombs, 95 Union St., Brighton, Mass.

Katie Louise Wills, World War I nurse. Have an important message. Anyone knowing her present address please send it to me. Mary Welsh, 7230 McPherson Blvd., Pittsburgh, Pa.

Back Issues Wanted: We need the October, November, and December, 1949 issues of "Trained Nurse and Hospital Review." If you can supply them please write to Josephine Kinman, R.N., Consultant Nurse, Occupational Health Division, State of Georgia, Department of Public Health, Atlanta., Ga.

Eva Block: I'd like to get in touch with you. Please write. Lola Gruen-Weber, M.D., D.D.S., 29 W. 75th St., New York 23, N.Y.

Graduates of Overlook Hospital, Summit, N.J.: The Alumnae Association is planning a reunion on June 27. There will be a tour of our new hospital, also a gala evening is planned. Please write to Mrs. Florence Angliss, Overlook Hospital, Summit, N.J.

Margaret McClanahan Stewart: Graduate of Baptist Memorial Hospital, Memphis, Tenn. Would like to hear from you. Mrs. Jean Foley Tierney, 3605 Ionia St., Seaford, N.Y.

Grant Hospital of Chicago School of Nursing Graduates: Our Alumnae Association is planning a Homecoming in June to celebrate its Golden Anniversary. All graduates please send your name (married and/or single) and year of graduation to Madelene Palmquist, R.N., c/o Grant Hospital, 533-559 Grant Place, Chicago 14, Ill.

Graduates of Englewood Hospital Training School for Nurses, Chicago, Ill.: Our Alumnae Association is making plans for its Annual Banquet, May 23 at the Windemere East Hotel. For reservations write Jeanette Defanis, 6001 S. Green St., Chicago., Ill.

Boston City Hospital School of Nursing graduates: Please send your name (married and single) and date of graduation to Mary Ankudowicz, 745 Massachusetts Ave., Boston 18, Mass. The school is planning to celebrate its Diamond Jubilee May 17-24.

E. J. Meyer Memorial Hospital graduates: A grand reunion party and dinner are being planned for June 8. For information write to Dorothy Sommer, 192 Shumway St., Buffalo 12, N.Y.

no baby sitters needed — 1 HOSPITAL

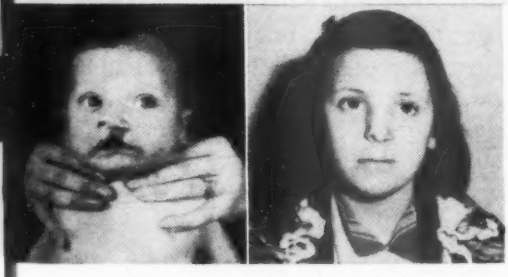
■ ON THE GROUNDS of the Hospital of Saint Barnabas and for Women and Children in Newark, N. J., a small brick building has come to life. Formerly used as a classroom, the house has been turned over to a group of healthy youngsters, who are doing their bit for the hospital by making it possible for their mothers to help staff this institution.

The idea of a day nursery evolved from an acute shortage of nurses at Saint Barnabas, which like other hospitals has been affected by the national shortage. Letters were sent to alumnae, asking how many inactive nurses would return to nursing if a day nursery were provided for their children. Then the New Jersey Hospital Association and the American Hospital Association were consulted to find out how to go about putting the plan into operation. The classroom was chosen as the nursery site since it was far enough away from the hospital proper to keep the children from coming into close contact with disease. Miss Ronna Vitale, a practical nurse with a flair for dealing with children, was chosen as nursery supervisor so that no registered nurse would have to be released from her regular duties. Miss Vitale cares for the children under the supervisor of the hospital's pediatric department.

Eighteen tots ranging in age from one to six years are now enrolled in the nursery which opened November 21, 1951. Under the plan, six to ten nurses who would otherwise have remained in their homes have returned to active duty. The mothers who took advantage of the opportunity became so interested in the project that they held a cake sale, baking the cakes themselves and selling them to doctors and other hospital personnel. The proceeds were used to buy a sand box and other equipment for the fenced-in playground adjoining the nursery.

Not only are the mothers able to supplement their family income through the nursery innovation, but by paying as little as a dollar a day—much less than a baby sitter would charge—their children are given expert care. The youngsters also gain in personality development from their contact with others. There are rest periods and play periods during the day. And [*Continued on page* 70]

2 INNOVATIONS — *cleft palate clinic*



by Sara H. Carleton

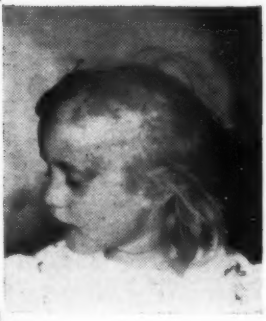
■ A NEW TYPE of clinic has opened at the Hospital of Saint Barnabas and for Women and Children in Newark, N. J. The inscription over the front entrance reads: "Cleft Palate Clinic," but this title is altogether too unassuming, since the clinic also serves as a rehabilitation center for those who benefit from its plastic surgery. And in addition to treating patients with cleft palates and harelips, the clinic doctors, operating under a group management plan, care for those suffering from burns, traumatic injuries, absence of the ears and nose, and various other types of acquired or congenital deformities.

Complete care of the patient is the keynote of the procedure adhered to by the clinic, which is believed to be the first of its kind in the country. To operate on a patient and let it go at that is no longer considered adequate. Once a month, heads of different departments are called in to review and confer on the various cases. In this manner, the patient's total personality is taken into account, with a view toward helping him to adjust both socially and vocationally.

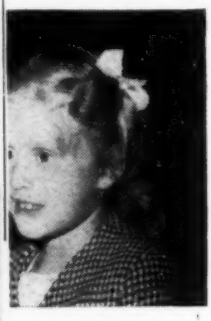
As a satisfied patient is a good advertisement, many clients find their way to the Saint Barnabas clinic through word of mouth. Others are referred to the clinic by various agencies. In the short span of its existence, the center has had as visitors plastic surgeons from home and abroad; nurses from all over the state, including visiting nurses and school nurses; representatives of social service agencies; and students of speech classes from the New Jersey State Teachers College. The clinic has achieved such popularity, and is working so effectively, chances are that hospitals in other states will soon follow suit by establishing similar clinics.

Typical of the young patients helped by the clinic is Shirley, a six-year-old girl who was handicapped by a cleft palate and harelip deformity when she arrived at Saint Barnabas. Like many other children with this affliction, she had a speech impediment which added to her embarrassment in associating with her friends and schoolmates. After Shirley was put through a series of tests in the various hospital departments, it was discovered that she had a

Young Jackie's partially descalped head looked like this before plastic surgery.



The denuded areas can be plainly seen in this profile view.



Jacqueline is pleased with the operative outcome which redistributed her hair.

high IQ and was extremely sensitive about her appearance and speech difficulty. Surgeons corrected her defective palate and lip but further rehabilitative help was indicated. Shirley is now attending speech classes and is showing rapid improvement. The teachers say her speech impediment will eventually be overcome. With psychological guidance, she is adjusting herself socially and makes friends easily. Only a little repair work on the nostril remains to make her rehabilitation complete, and this will be undertaken when she is past adolescence.

Then there is Jacqueline, an attractive, photogenic five-year-old blond who had just begun her first year in school when she was brought to the clinic for plastic surgery. Two years before she had been partially descalped when she was burned with hot grease. As a result, she had become extremely self-conscious about the bald areas on her head. Jacqueline's rehabilitation was effected after several skillful grafting operations were performed.

An unusual case, with psychological implications, is that of Gary D., a sixteen-year-old boy afflicted with a cleft palate and harelip deformity, who had been sent to Annandale Reformatory for stealing automobiles. Although he had undergone operations in earlier years, the surgery had been done by an unqualified doctor, with discouraging results. His disfigurement, added to his difficulty in talking, had made him unpopular with other young people of his age. While at Annandale, he made the acquaintance of a state rehabilitation officer who interceded in the boy's behalf. But before the officer had time to act, the boy escaped from Annandale. Later he was recaptured and sent to Bordentown Reformatory. The psychiatrist at the latter institution, believed that Gary was "good material" and might profit immeasurably from the thorough treatment offered at Saint Barnabas. In Gary's case, the change in his appearance proved worth the effort, not only in his social adjust-

ment but in his entire outlook on life. The boy was paroled from Bordentown and is getting along excellently in a trade school. He no longer feels that he is an outsider or an outcast, and he is able to meet the challenges of daily living successfully.

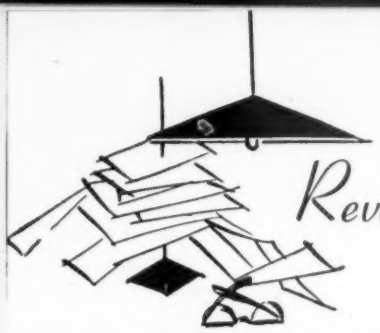
While many clinic patients fall into the younger age group, there are numerous adults who request treatment. It is interesting to note that a few of these older patients complain of defects that are scarcely noticeable. A patient, for example, may insist on plastic surgery to alter the shape of his nose, even though there is no unusual deviation from the normal. Undoubtedly, these patients who are unduly sensitive about their appearance have feelings of inadequacy which cannot be dispelled by plastic surgery alone.

Each patient is given a psychological examination on admittance to the clinic, but since a majority of the patients are normal mentally, psychiatric aid is rarely required. In cases where it is, though, the clinic refers the case to the proper authorities. Working in close cooperation with such agencies as the State Crippled Children's Commission and the New Jersey Rehabilitation Commission, every effort is expended to help patients plan their lives to their best advantage. The Crippled Children's Commission is especially concerned with the younger patients, while the Rehabilitation Commission devotes the greater part of its energies to helping older, deformed patients, and placing them in jobs. Patients pay according to their means; and no one is turned away. When an applicant cannot meet his expenses, the clinic underwrites the total loss through voluntary contributions. The specialists donate their time to the clinic.

The clinic leaves no stone unturned in considering the welfare of its patients. There are speech classes for children, and classes in speech and psychology for parents with younger children. These classes are held in the early evenings as well as in the daytime so that fathers may attend them if they wish. When the patients live too far away to attend speech classes, the clinic tries to refer them to speech therapists in their own localities. School authorities are also called upon as the occasion demands, as are other doctors, who are able to carry on after the initial visits have been made at the clinic.

The clinic doctors perform approximately 1,200 operations annually. In order to conserve blood bank supplies, blood counts are taken on all patients two months or more before any operations are performed. If any of the patients are anemic, they are sent home on a high protein diet, with liver extract and iron, until they are in good condition for the operation. Cleft palates, harelips, and total absence of ears are among the conditions most frequently encountered at the clinic. But birthmarks also account for a high percentage of the disorders, as do cases of angioma, or tumors of the blood vessels.

Credit for the founding of this unique clinic [*Continued on page* 74]



Reviewing the News

▶ COLLEGE FOR NURSES?—a discussion of this question, including analyses of the deficiency in nursing service and the relation of education to supply as well as chapters on the baccalaureate, supplementary, and graduate programs, is contained in a new book by Dr. Margaret Bridgman, former Dean of Skidmore College and now a consultant on the staff of the NLN's Department of Baccalaureate and Higher Degree Programs. The book *Collegiate Education for Nursing*, published by the Russell Sage Foundation, may be ordered from the NLN. A review of this publication may be found in this issue, page 32.

▶ COURSES AND MEETINGS: The Sixth Annual Gulf Coast Regional Conference on Industrial Health is scheduled to be held at the Shamrock Hotel, Houston, Tex., October 1 through October 3. Special nursing sessions will be held on the 2nd and 3rd of October and will include programs for both graduate and student nurses . . . A workshop for industrial nursing consultants is to be conducted June 15–20 by the Section of Occupational Health, Department of Public Health, Yale University. The theme of the workshop is "The Promotional Responsibilities of the Industrial Nursing Consultant." Only graduate nurses with at least six months' experience as nursing consultants will be accepted. Tuition is $25. Applications may be sent to Mary Louise Brown, Assistant Professor of Public Health, Section of Occupational Health, 310 Cedar Street, New Haven 11, Conn. . . . The American Association of Nurse Anesthetists has approved the school of anesthesia at General Hospital, Kansas City, Mo. Those interested in the course should contact the Anesthesia Department, General Hospital, 24th and Cherry, Kansas City, Mo. . . . Texas nursing organizations, including Texas Graduate Nurses Association, the State League of Nursing Education, the State Organization for Public Health Nursing, and the Students Association, will convene at the Rice Hotel in Houston, April 21-25 . . . The Twelfth Annual Convention of the National Association for Practical Nurse Education will be held at the Hotel New Yorker, New York, N.Y., May 4-7, inclusive.

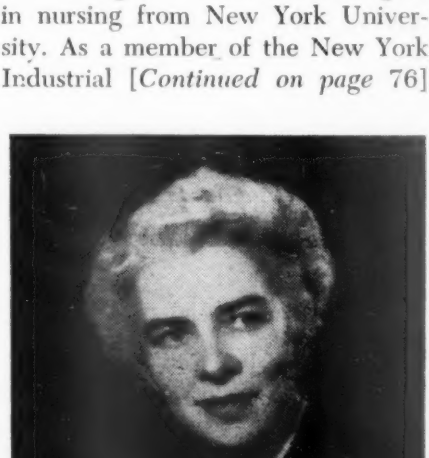
▶ CITED: The Meritorious Unit Commendation, the Army's second highest unit award, has been given the 11th Evacuation Hospital. Between May, 1951, and June, 1952, this 450-bed hospital, operating in a forward combat area, treated 17,000 UN patients. Less than one per cent

of these patients died. The Bronze Star Medal has been awarded to four nurses assigned to this unit. They are Maj. Alice B. Clark, ANC, chief nurse,—for outstanding leadership; Maj. Isabel M. Kent, ANC, nurse anesthetist,—for outstanding success in teaching anesthesia procedures to other nurses; Capt. Mary W. Wilborne, ANC,—for displaying exceptional ability in her work with the artificial kidney; and Lt. Elizabeth M. Grant, ANC,—for heroism shown in helping patients to safety during a fire in the hospital.

▶ CAPITOL COPY: *The People Speak*, Volume 5 of the Magnuson Report on the health needs of the nation, is now available. It may be obtained for $2.50 from the Superintendent of Documents, Washington 25, D.C. . . . A panel of experts, appointed by the National Research Council, is to be responsible for the allocation of gamma globulin. Chairman of the panel is Dr. Hugh Leavell of the Harvard School of Public Health . . . The Food and Drug Administration has warned manufacturers and repackers of ophthalmic solutions that such solutions will be considered adulterated or misbranded if they are found to be unsterile. Investigation reveals that serious damage and even total loss of vision has followed the use of solutions which have been contaminated with viable micro-organisms . . . A total of 1,980 Hill-Burton hospital projects had been approved by the end of 1952. Of these, 1,106 were already completed. . . Two new bills, H.R. 2244 and H.R. 2245, recently introduced by Rep. James J. Delaney (D., N.Y.) require manufacturers of foods and cosmetics to prove that any chemical additives which they may employ, such as preservatives, etc., are not harmful to the consumer.

▶ NEWLY APPOINTED director of nursing services of the National Foundation for Infantile Paralysis is Eleanor E. McGuire, formerly industrial health consultant for *Time*, *Life*, and *Fortune*.

Miss McGuire has also served as a senior grade lieutenant in the U.S. Navy Nurse Corps, chief nurse for the Sylvania Electric Products, Inc., and most recently as director of the practical nursing program of The Bergen County, N.J., Vocational and Technical School. She is a graduate of the Metropolitan Hospital School of Nursing and holds a B.S. degree in nursing from New York University. As a member of the New York Industrial [*Continued on page* 76]



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Modern Dentistry

[*Continued from page* 39]

faced with the problem of a patient who gags easily. Since this will cause inaccuracies in the models, gagging must be controlled. In the majority of cases, the cause is psychic, although other reasons, such as stimulation of the glossopharyngeal nerve or chronic sinusitis may be at fault. Various topical anesthetics have been employed, but there is danger in their use due to the resultant loss of the gag reflex. The psychological approach to the patient, distracting his attention by talking to him, or having him pant or breathe through the nose, may prove successful. The position of the patient may also be adjusted. The head should be forward and tilted slightly downward to prevent saliva or the impression material from collecting at the back of the throat and choking the patient.

Fixed bridge and partial removable dentures are constructed when a patient has some teeth which may be utilized as a framework. Even though only one tooth is absent, its replacement is essential to prevent migration of other teeth, food impaction areas, and malocclusion. If removable dentures are to be worn, the importance of wearing them during the waking hours must be stressed, so that the adjoining or opposing teeth do not shift. Proper cleansing is also important to prevent damage to and ultimate decay of surrounding teeth.

Many patients, particularly those in their forties or beyond, need complete replacements for lost teeth. Scientific advancements in full denture construction have resulted in dentures which may be worn comfortably, enabling the wearer to eat most foods. However, any patient with a prosthesis should avoid excessively fibrous or adhesive foods. Patience is required in learning how to live with a prosthesis, and nervous habits such as teeth-gnashing, or unseating the denture with the tongue must be corrected.

Among the newer developments in dentistry are the airbrasive technique for removing decay, and the use of vitallium pins through the jaw to hold dentures in place permanently. However, neither of these procedures is yet in widespread use.

The psychological approach to any patient is important, especially to the young. Parents should be instructed not to use the visit to the dentist as a threat of punishment. Ideally, the child should accompany the parent to the dental office several times, and become familiar with the surroundings before actual examination is undertaken. Although the dentist tries to prevent pain, it may still be present with treatment. The properly prepared child undergoes treatment, even if painful, more readily and in a happier frame of mind than one who is fearful of the unknown. The child who learns to accept dental treatment without fear will usually continue his dental health program as an adult, visiting the dentist regularly at six-month intervals.

Blueprint

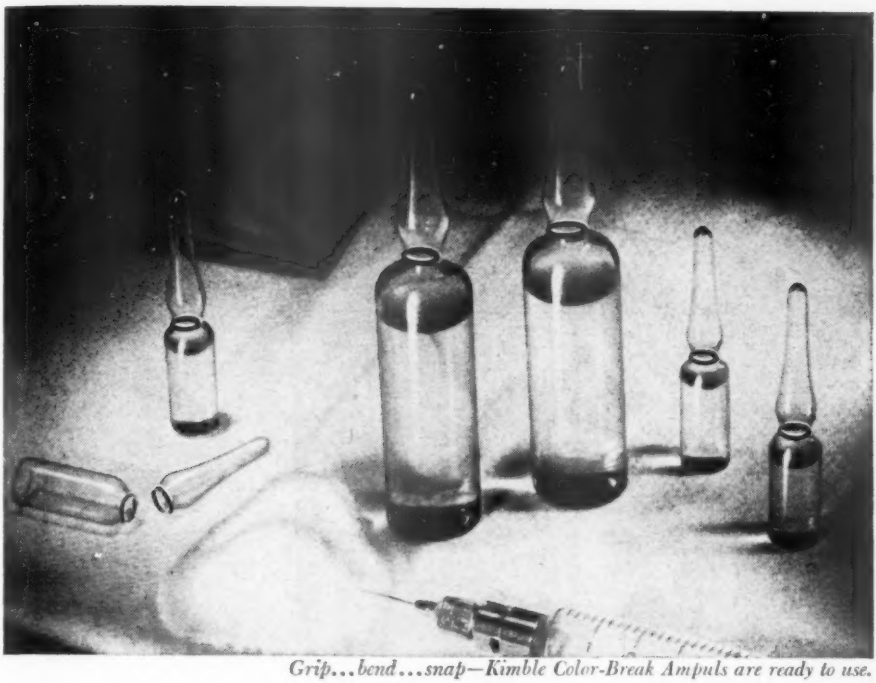
[*Continued from page* 35]

detailed report, assumes almost as much importance as the separation of church and state, sounds plausible to the objective reader. But the questions now arise: can universities and colleges assume this new responsibility? Can they do the job effectively? Dr. Bridgman's emphatic answer is that they can, if they are apprised of the facts, and they must if health services are to be maintained "at the level demanded by our social development."

Unfortunately, it is evident from Dr. Bridgman's report on existing baccalaureate nursing curricula, that many leaders in higher education have not been apprised of the facts. In fact, there seem to be almost as many educational shortcomings in collegiate nursing schools as there are in hospital schools. One practice of so-called collegiate schools which Dr. Bridgman roundly scores is that of offering the major curriculum in nursing, "not in the degree-granting institution with teaching by members of its faculty, but in hospital schools with instruction by hospital school teachers in classes usually shared with diploma students." In January, 1951, about half of the 9,184 students in degree programs were earning their degree in this manner. Another pernicious practice of colleges, according to the author, is granting "blanket credit" for the diploma course in the noncollegiate hospital school . . . without evaluating the student's knowledge and skills in nursing." In numerous cases, the college or university provides academic courses only. Moreover, Dr. Bridgman observes that graduate programs which lead to the masters degree are at present little differentiated from those leading to the baccalaureate degree.

These current educational practices on the part of universities and colleges, which are careful to maintain high standards in other professional schools or departments under their auspices, may be attributed to confusion and downright ignorance of nursing education, says Dr. Bridgman. It is her hope that this book may correct some of their misconceptions as well as challenge them to introduce some sound basic nursing curricula.

It is likely that the book will clarify some important educational issues, and it is also likely that it will antagonize the group that favors the continuance of the hospital school. For although Dr. Bridgman does not shut the door on the hospital school completely, she leaves it only slightly ajar. She recommends "continued efforts to establish uniformly good standards in hospital schools," but states: "Evidence is accumulating that both acceleration and the production of better qualified graduates can be accomplished through concentrated emphasis upon educational purposes, more and better teaching, and less repetitive practice. Such improvements involve financial problems . . . and it is doubtful whether hospitals can or should continue to carry this educational respon-



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sibility longer than the transition makes necessary."

Objective readers cannot fail to be impressed with Dr. Bridgman's presentation and logic. Nor can they cavil at her thesis that nurses must be better prepared to meet their ever-increasing responsibilities in numerous health fields. What they will probably object to is the assumption—and it is purely an assumption—that the average product of hospital schools is unequal to the demands of staff level nursing. Granted, Dr. Bridgman's conclusion may be valid—it, in fact, may be the writing on the wall—but the statistical returns are not yet in from experimental concentrated programs. And there is still no assurance that, in view of present attitudes, there will not be a long and stormy transition period.

Dr. Bridgman herself does not discount the difficulties inherent in reorganizing the traditional system of nursing education. She is fully aware that her plan for more and better nurses will require a drastic change in traditional attitudes. She also realizes that there will be financial problems involved both in the provision of scholarships and the setting up of nursing departments within colleges. However, she is convinced that none of these difficulties is insurmountable if nurses, members of the allied professions, and educators, agree on general policies, and do their part in winning the support of the general public. She implies that there is too much at stake to admit of failure, particularly at this confused stage of the game.—by Frances Lewis, R.N.

No Sitters

[*Continued from page* 58]

as an added service for mothers, diapers are washed, enabling the children to go home spic and span. Some mothers bring their children's lunches, but most of them prefer to contribute twenty-five cents a day for food for the noon meal. Milk and fruit juices are supplied by the hospital. Although the nurses bring their offspring to the hospital at 7 A.M., following breakfast at home, and pick them up when they are off duty, nursery hours are flexible. If desired, the children may remain at the nursery until later in the day when their fathers are able to call for them.

The success of Saint Barnabas' experiment in providing nursery care is shown by the interest it has aroused in neighboring hospitals. For needless to say, these institutions, too, are afflicted by the nurse shortage, and are looking for ways to attract inactive nurses back to active duty.

A grant totaling $35,837 has been made to the NLN Committee on Careers in Nursing by the National Foundation for Infantile Paralysis. The grant will be used to further the recruitment of students for both professional and practical schools of nursing by underwriting the Committee's field services program. This is the third year that money from the NFIP has been so utilized by the Committee. However, the NFIP has assisted the Committee financially since 1949.

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R. N. Speaks

[*Continued from page* 31]

authoritative positions who have so little background in organization affairs that their education must be at the cost of progress. Yet, the whole trend today is toward preparing people for organizational leadership. If we can make progress only through organization then the quality and experience of our leadership is of the utmost importance.

We don't think hard enough or care sufficiently to select some fresh nurses who have demonstrated their value locally—to boldly propose their names for state and national offices even though they may not be widely known. Also, we don't work hard enough to help nurses from the ranks to get the freedom from their jobs that would enable them to take office without too much personal sacrifice.* In fact, we have a very poor record of representation of the rank and file at policy-making conventions. The ANA registration figures at the last Biennial by sections bear this out:

Private duty	314
Men nurses	31
General duty	506
Industrial	128
Administrators	2,496

Yes, there are still many weaknesses in our professional organizations, and they still suffer from overweight of administration leadership in key positions.

—Alice R. Clarke, R.N., Editor

*Who was the last ANA president to hold a position directly concerned with patient care, and in what year? A year's free subscription to **R.N.** for the correct answer.

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Cleft Palate Clinic

[*Continued from page* 61]

goes to New Jersey's Dr. Lyndon A. Peer, a noted plastic surgeon. Dr. Peer started the clinic on a financial shoestring, devoting many tedious hours to the task of soliciting funds. At first, it was no easy matter to convince people that such a clinic was essential, but eventually the idea aroused interest, and initial backing was assured by the Crippled Children's Commission. A number of Dr. Peer's private patients have made voluntary contributions. The Junior League of Newark is also a generous donor, and the Turrell Foundation of the Oranges has a grant for the benefit of speech defects. Further support comes from Tufts Dental College in Medford, Massachusetts.

Dr. Peer had several reasons for abandoning the plastic surgery clinic he had been conducting for 15 years in order to proceed with his new venture. "One of the clinic's aims," he states, "is to utilize all methods which will most effectively obtain the best results and to do so constantly through observation and trial of new procedures." Recently there has been controversy over the best age at which to operate for cleft palate, harelip cases, and hand deformities. Since plastic surgeons differ in their opinions, it is hoped that the matter may be determined through the work carried on at Saint Barnabas. Another problem to be solved is how early skin grafting can be done in burn cases.

When Dr. Peer opened the Saint Barnabas Clinic on May 3, 1951, another cleft palate clinic in Lancaster, Pa. was already functioning. Although Dr. Peer derived his idea in part from the Lancaster clinic, established by Dr. Herbert Cooper, a pioneer in harelip cases, the plan for his clinic at Saint Barnabas had been evolving in his mind over a long period. Both the cleft palate center at Lancaster and the Newark clinic follow the group management plan, but the work at Saint Barnabas is broader in scope, since it is not confined to cleft palate and harelip cases. The Saint Barnabas clinic will be two years old next month. Its staff can look back on these first years with satisfaction, and look forward to many more years of service in a field where a great need exists.

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News

[*Continued from page* 63]

Nurses Club as well as the American Association of Industrial Nurses, Miss McGuire has taken an active part in nursing organization; she is also a member of the National League for Nursing and the American Nurses Association.

Her current assignment entails liaison work with other organizations providing services to polio patients. She will serve under the direction of Dr. Curtis F. Culp, NFIP's director of medical servies, succeeding Margaret A. Losty who is entering another branch of nursing consultative services.

▶ WANT TO JOIN? The NLN has authorized a Council on Psychiatric and Mental Health Nursing. This is the first interdivisional council of NLN individual members to be organized, and membership is open to all those interested—non-nurses and nurses not engaged in this special field of nursing as well as psychiatric and mental health nurses. It is only necessary to indicate an interest in becoming a member of the council when applying for 1953 membership in the NLN. There are no extra dues for council membership.

▶ AAIN MEMBERS will gather in Los Angeles this month—April 18 to 24—for their 11th annual conference. The conference will feature a series of "shop talks" designed to help industrial nurses improve and better organize their health services. Chair-

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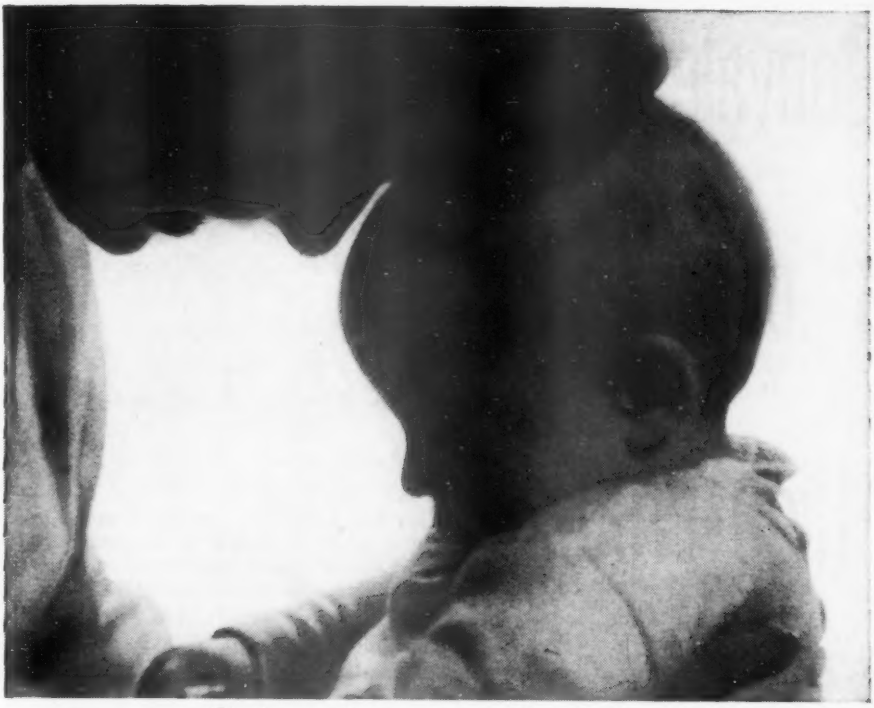
man of the conference is Mary Mulvahill of North American Aviation Corp. Elise Williams of Northrop Aircraft Corp. will be co-chairman. Miss Williams is president of the Southern Chapter of the AAIN. The AAIN gathering will be held in conjunction with the 1953 Industrial Health Conference.

▶ DOCTOR-PRESS-RADIO Code of Ethics has been adopted by the West Virginia State Medical Association, West Virginia State Newspaper Council, and West Virginia Broadcasters' Association. The code was worked out by Dr. E. L. Gage, chairman of the West Virginia State Medical Association's Public Relations committee, and representatives of the press and radio. Among other things, the code states: that there shall be official spokesmen, designated by county and state medical societies and by hospital staffs to give information promptly on health and medical subjects; that hospital spokesmen act only in the absence of or at the request of the attending physician. It describes the information which a physician may ethically give to the press in cases of accident, "illness of a personality in whom the public has a rightful interest" and in cases of unusual illness, injury or treatment; it establishes the right of the private physician to have his wishes respected regarding the use of his name or a quotation; and it emphasizes the fact that no doctor shall give information which jeopardizes "the hospital-doctor-patient relationship or violates



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Write today for your free copy "Feeding the Sick and Convalescent." Knox Gelatine, Johnstown, N. Y., Dept. RN

1. Howard, J. E. Protein Metabolism During Convalescence After Trauma. Arch. Surg. 50:166, 1945.

2. Co Tui, Minutes of the Conference on Metabolism Aspects of Convalescence Including Bone and Wound Healing. Josiah Macy, Jr. Foundation, Fifth Meeting Oct. 8-9, p. 57, 1943.

3. Whipple, G. H. and Madden, S. C. Hemoglobin, Plasma Protein and Cell Protein: Their Interchange and Construction in Emergencies. Medicine 23:215, 1944.

4. Mulholland, J. H., Co Tui, Wright, A. M., Vinci, V., and Shafiroff, B. Protein Metabolism and Bed Sores. Am. Surg. 118:1015, 1943.

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the confidence, privacy or legal rights of the patient." Press and radio representatives agree to use editorial judgment to avoid publishing material which exploits patient, doctor or hospital, and to make all reasonable effort to obtain authentic information from the designated official spokesmen. Spokesmen may be quoted by name and title without violating medical ethics.

▶ A STANDARD FEE PLAN has been approved "in principle" by the House of Delegates of the California Medical Association which has authorized any county medical society to set up such a program, experimentally, at any time. The plan works as follows: Each doctor in an area would set his own fee schedule following which the county medical society would then establish a county "average-fee" schedule based on these figures. No doctor could charge a fee in excess of this schedule without first obtaining the patient's agreement. Any doctor could, however, charge less than the "ceiling" fee.

▶ NEWSLINGS: Pamphlet No. 182, *Getting Ready to Retire*, by Kathryn Close, contains many helpful suggestions on how to plan for your retirement years. The booklet may be obtained for 25 cents from Public Affairs Pamphlets, 22 East 38th Street, New York 16, N.Y. . . Holy Family Hospital, built and operated under the direction of the Medical Mission Sisters of Philadelphia, is the first Catholic Hospital on the Gold Coast. The hospital, located at Berekum, British West Africa, was opened in October . . . Those who were in attendance at sessions of the British Association for the Advancement of Science, Belfast, Ireland, heard that Britain also has its problem of the aging. To provide for even 10 per cent of Britain's 7 million "old folks" would require the allocation to the aged of some 20,000 of the new residential homes, it was revealed... The state supreme court of Colorado has ruled that Emma Cornali, one-time nurse in the polio isolation ward at Corwin Hospital, Pueblo, Colo., may collect workmen's compensation for contracting polio at the hospital. In so doing, the higher court reversed a previous decision reached by a Denver district court.

▶ SNA GROUP INSURANCE of some type is offered by approximately 33 states, an increase of over 100 per cent in the past 20 months, replies to a recent ANA questionnaire reveal. The most common type of insurance offered is sickness and accident insurance which is carried by 28 of the reporting states. (Ten states did not report.) Twenty states report either hospitalization and surgical plans or hospitalization plans and of these states, ten offer medical care insurance in conjunction with hospitalization and/or surgical benefits. Only five of the reporting states carry retirement policies, four of which also carry life insurance. Professional liability insurance, distinct from the ANA individual Professional Liability Insurance Plan, is offered by four reporting states.

PAIN PREVENTION

[*Continued from page* 43]

and has been employed in the treatment of ventricular and auricular arrythmias and extrasystoles appearing either in cardiac disease or during general anesthesia.

Among the newer anesthetics are a number of compounds which are only slightly soluble such as ethyl aminobenzoate, orthoform, and butyl aminobenzoate. Unsuited for injection purposes, these drugs are used as powders or made up into ointments or lotions for topical application to ulcers and wounds. Since they are poorly absorbed, they are less toxic than are the salts of the water-soluble compounds, and as a rule their anesthetic effect, though less powerful, is more prolonged than that of the soluble anesthetics.

Although not foolproof, local anesthetics, when used with care are a valuable addition to man's arsenal in his ever-present conflict with pain.

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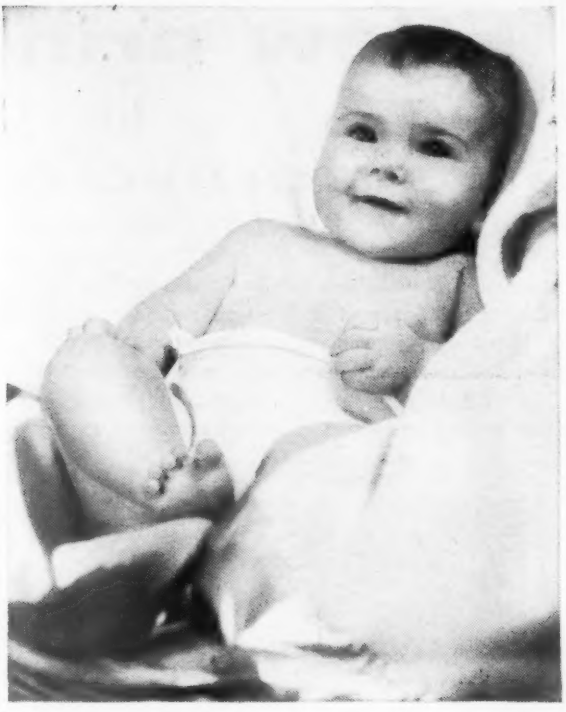

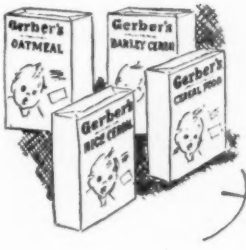

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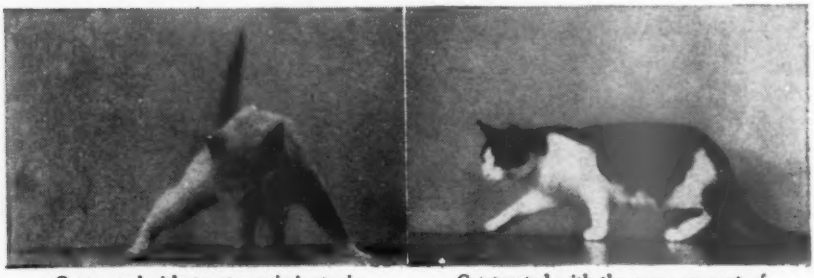

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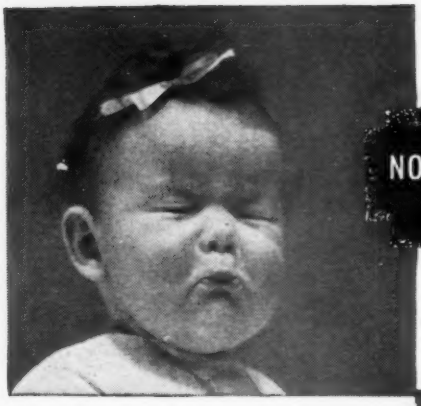
GENERAL STAFF NURSES: For 160 bed general hospital, community of 25,000 located halfway between Yellowstone and Denver in the oil capital of the Rockies. Starting salary $253 plus laundry. Then $263, $274, $285, $297 at 6 month intervals. Annual increases there-



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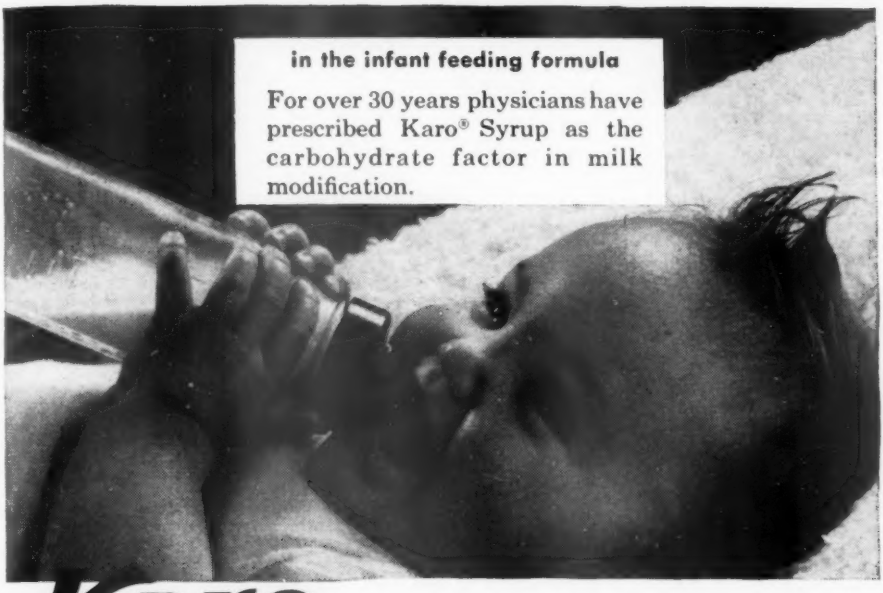
NURSE ANESTHETIST: No nights or weekends. Salary $350 monthly, plus maintenance.



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NURSES: How would you like to practice nursing from June 20th thru Aug. 11th among the aspen and pine trees at a mountain Girl Scout Camp? Requirements: R.N., First Aid Training, 21-35 yrs. Write Pueblo Council of Girl Scouts, 322 West 5th St., Pueblo, Colo.

NURSES: The State of Maryland is opening a new unit at Mount Wilson's Tuberculosis Sanatorium and has immediate openings in the following positions: Director of Nurses ($4620-$5775 a year); Assistant Director of Nurses ($3900-4875); Supervisor of Nurses ($3420-4275); Charge Nurses ($3240-4050); Registered Nurses ($3000-3750). This hospital is located outside of Baltimore City. The positions of Director and Assistant Director require a Bachelor of Science Degree. Positions are under the State Merit System and insure security, liberal vacation and sick leave, automatic salary increases and retirement benefits. Applicants should contact Dr. Leon Heatherington, State Department of Health, 2411 N. Charles Street, Baltimore 18, Md.

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STAFF NURSES: For modern 650 bed tuberculosis hospital, affiliated with Western Reserve University. 40 hr. 5 day wk. Salary $280 to $310 with automatic increases. Full maintenance available at minimum rate. Usual holidays, vacation & sick time allowance. Advancement for eligible applicants. Meets approved minimum employment standards of the State Nurses' Assn. Apply to: Director of Nursing, Sunny Acres Hospital, Cleveland 22, Ohio

STAFF NURSES: In hospital for children with rheumatic fever. Excellent salary, good working conditions, maintenance, vacation. Near New York City. Apply Medical Director, Irvington House, Irvington, N.Y.

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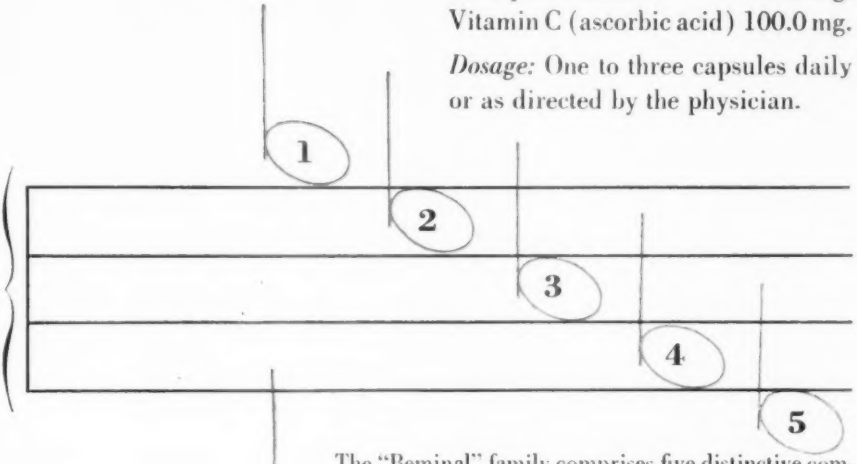

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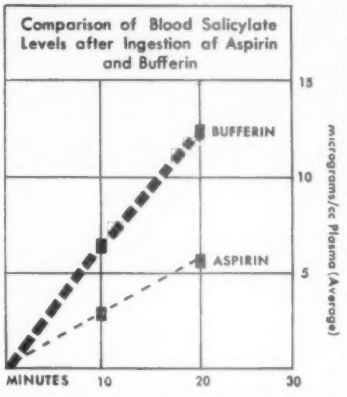

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1. Effect of Buffering Agents on Absorption of Acetylsalicylic Acid. J. Am. Pharm. Assoc., Sc. Ed. 39:21, Jan. 1950
2. Gastric Tolerance for Aspirin and Buffered Aspirin. Ind. Med. 20:480, Oct. 1951

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